S. HRG. 100-942

VANISHING NURSES: DIMINISHING CARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

PHILADELPHIA, PA

APRIL 6, 1988

Serial No. 100-19

U.S. GOVERNMENT PRINTING OFFICE

88-594 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-2

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VANISHING NURSES: DIMINISHING CARE

WEDNESDAY, APRIL 6, 1988

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Philadelphia, PA.

The committee met, pursuant to notice, at 9 a.m., at the James Crumlish Ceremonial Courtroom, Philadelphia, PA, Senator John Heinz presiding.

Present: Senator Heinz.

Staff present: Larry Atkins, minority staff director; Kimberly Kasberg, research associate; and Madelyn Glist, communications assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, PRESIDING

Senator HEINZ. Good morning. My name is Senator John Heinz. This is a hearing of the Special Committee on Aging of the United States Senate. We welcome you one and all, and I want to say that I particularly appreciate the witnesses that we have today coming from both near and far. I look forward to your testimony, and I want to start our hearing with an opening statement.

Recent nurse strikes in Los Angeles, New York and even Butler, Pennsylvania are symptoms of a serious disease festering in our Nation's health care delivery system. At the root of that illness is a nurse shortage severe enough to begin endangering the lives of patients. Hospitals, nursing homes and home health agencies can't find the nurses they need. The nursing staffs they have are being stretched thinner and worked harder.

The signs of the nurse shortage are abundant. Over 80 percent of hospitals and 57 percent of nursing homes have reported that they can't fill their nursing positions. In 32 percent of the nursing homes, there are not enough qualified nurses to even meet minimum standards. In just the last 4 years, vacancy rates in hospital nursing posts have more than doubled. Today, the average hospital is missing 11 percent, about 1 out of 9, of its nursing staff.

Patient care is suffering as a result. Hundreds of protest forms filed by nurses with New York and Pennsylvania hospitals point to conditions unsafe for patients due to staffing shortages. They talk about emergency rooms without enough staff to cope with multiple emergencies; specialty wings staffed with inexperienced or untrained nurses; longer shifts or double shifts to stretch the nursing staff further; shortened recovery time for patients in specialty units; closed hospital beds and even postponed surgeries. The result, among other things, are stress, frustration, mistakes, and exhaustion. They are chasing nurses out of these settings and too

often out of the profession and making it harder to attract new nurses in.

The irony, of course, is that this nurse shortage comes at a time when we have more nurses than ever before, and when the nurse-patient ratio is double what it was 10 years ago. The problem is not that we have fewer nurses—it is that we need more nurses. More nurses are needed in hospitals to take care of a patient population that stays for less time, but is sicker while it's there. More nurses are needed in nursing homes and home health care agencies to take care of the growing number of patients being discharged into these settings, particularly when these patients are sicker than in the past. More nurses are being used to perform nonmedical functions in the health field, like quality review and insurance claims adjustment. And all of these various settings are competing for the limited supply of nurses we have. With fewer and fewer students choosing to enter the nursing profession, we face the potential for a long-term shortage of nurses that would be very, very difficult to correct.

The purpose of our hearing today is to give us an opportunity to understand the causes of today's nursing shortage and discuss the solutions that are possible.

This morning we have, as I pointed out, a number of witnesses. We have a total of eight, two panels, and I'd like to ask the first panel of Marie W., Joann B., Dick Loughery, and Patricia Prescott to please come forward.

Since we have two panels of witnesses, I'm going to urge our panelists to please keep their testimony to 5 minutes, if they can. That way, there will be an opportunity for me to ask questions. We will have to conclude this hearing pretty promptly at 11 o'clock, and I will try and keep my questions as succinct as possible.

I would like to ask Marie W. if she would be our leadoff witness. Marie.

STATEMENT OF MARIE W., R.N. CCRN, STAFF NURSE/CHARGE NURSE, INTENSIVE CARE

Ms. W. I would like to express my appreciation for being asked to come and testify here today about something that is of very great importance to myself and many of my colleagues, and that is the effect of the nursing shortage on patient care in the acute care setting.

In my written statement, I've provided a scenario of what it is that I do, and I won't go through the whole statement because it is quite lengthy. The purpose of putting that in there is that what is oftentimes the public image of what a nurse does is very different from what a nurse really does do. So I would encourage people to read through my statement to find out what it is that I do in an intensive care setting.

Senator HEINZ. Without objection, your entire statement will be a part of our record.

Ms. W. Thank you. The primary reasons that patients are hospitalized is to receive nursing care. Many of the tests, the treatments, the medical appointments, et cetera, these are not nursing care, they can be done on an outpatient basis, so the only reason

patients are in the hospital and are staying in the hospital is to receive the nursing care that goes along with these other tests and treatments.

What happens when there aren't enough nurses? First, nurses establish priorities based on patients' physical needs, similar to a triaging system which is utilized in emergency rooms. Anything that's life threatening gets taken care of first and then in descending priority. Oftentimes though, you don't have the time to do those things in descending priority. You're just dealing with the life threatening problems.

What is not getting done? Let's consider the following:

One, monitoring patients as frequently as needed. For example, a patient who has had a head injury should be checked every hour, but may only be checked every 4 hours. During that time, significant problems can develop and treatment will be delayed which could affect the patient's outcome; that is, further physical deterioration or even death.

Two, prevention of complications. This is a big focus of nursing care. Not being able to turn patients as much as they need, get them out of bed, clean up body fluids that if left on the skin can cause severe skin problems, changing dressings, IV lines and intravenous sites. Patients can develop life threatening infections if these procedures are not performed as needed. And oftentimes they develop infections with such superbugs that even the antibiotics that we do have can't cure the infection.

Three, patient education on discharge. Patient education is also a very big thing that nurses are trained to do, but unfortunately, you don't get to do much of it at all. It would include aspects of the patient's illness, what they are in the hospital for and why, ways to identify medical problems, when to seek medical help, how to prevent a recurrence of a problem. Patients do not get much of this from other medical staff, and now they're not getting it from the nursing staff as well. Patients, then, out of ignorance will develop medical problems again and need to be treated again and need to be hospitalized again. This could be prevented.

Four, emotional support for the patient and the family. Studies have shown over and over again that stress can have an adverse effect on the duration and the severity of an illness. Nurses are so busy dealing with the acute manifestations of illnesses, they have little time to talk and provide emotional support for the patient and the family.

Five, this is kind of a catchall category that I created to clear up loose ends. It includes things like reading charts, checking consult forms if they need to be filled out, recommendations, finding out the different specialties that have consulted on the patient, evaluating the need for specific tests and treatment. One of the things that I do as a nurse is to make sure that everything is done for the benefit of the patient. I don't have time now to run and try and check all these things, to look over charts, to see if these tests are being run that need to be done, things like that. It's not really my responsibility, but in the setting that I practice in, I often do this. The end result when I do it is it prevents escalation of costs, helps the patient and things like that. Now, we're not doing it, so it is causing a lot of problems with patient care and costs.

Much research has documented that if nurses have the time to provide adequate nursing care, that patients get out of the hospital faster, they are in a better state of wellness when they do leave, they do not have as many long-term serious side effects from their disease, and they have enough information to prevent further recurrence of their disease, or to minimize potential problems.

How bad is it? I would like to give two examples of problems with providing safe nursing care in the intensive care unit.

Problem number one: A nurse was assigned the care of two very critically ill patients. Both of them had very unstable blood pressures. One patient had a very severe infection, his lungs weren't functioning, so he was on a respirator. His liver wasn't functioning, so he was slowly bleeding from many places because his liver couldn't make the clotting factors necessary to stop him from bleeding. He was receiving numerous blood transfusions, was on three different potent kinds of medications to help raise his blood pressure, which weren't working very well. His blood sugars had to be checked every hour because they were either too high or too low.

The other patient was also on two potent medications for his blood pressure, which also weren't working too well. He was agitated and kept trying to pull his IVs out, the ones that contained the blood pressure medications trying to stabilize him.

The patient's room was a pretty fair distance from the other patient's room, so the nurse had to run back and forth constantly, check this one patient's blood pressure and run over here and do something else with the other patient.

Each of these patients should have had one nurse each according to the nursing care classification system used in the hospital to determine how many nurses are needed for each patient. There were no other nurses who could help because they were as busy or more busy than that nurse. No other nursing personnel such as orderlies or aides were available. The head nurse was out of the unit.

Throughout the day in order to make a decision on what to do next, the nurse had to decide who would suffer the most harm if a certain task wasn't done, because it all needed to be done, but it was impossible to get it all done.

Example number two: Nurse A was responsible for providing care for two patients who were very critically ill. Nurse B was in the same area of the unit. She also had two patients who were very ill. And according to the classification system that I mentioned, each of these patients should have had one nurse each. Nurse A spent what little time she had, which wasn't much, taking care of one of Nurse B's patients, because the other patient was so unstable for the first 5 hours of the shift that Nurse B couldn't leave that patient's bedside.

Around 1:30 in the afternoon, Nurse A sent Nurse B out to the nurse's lounge just to wolf down her lunch in about 10 minutes. While Nurse B was at lunch, Nurse A had to put back a patient of Nurse B's in a chair that this patient was tipping over. While she

was doing that one of the EKG monitor alarms rang. It took a couple of minutes to get this patient back into the chair, and Nurse A then went to investigate whose alarm was ringing. It was the other patient of Nurse B whose heart had stopped, and she had stopped breathing.

At that time, Nurse A was the only person, nursing, or nonnursing, present within shouting distance. She had to scream for help three times before anyone heard her. Needless to say, that patient didn't survive.

Nurses are in very precarious positions from a legal and ethical standpoint. They know it. That's one of the reasons that they're leaving. Patients are suffering more complications, are in the hospital longer, are coming back more and more frequently, and possibly dying because nurses don't have the time to do what they have the knowledge and skill to do.

Nurses will continue to leave the bedside if day after day they are placed in situations where they know they are not able to provide adequate nursing care. They are getting burned out from doing constant crisis-intervention type of nursing, and they are constantly afraid of losing their license to practice, because they know what they are not getting done and the potential for patient injury.

One of the reasons I chose nursing as a career was that in whatever I chose to do, I wanted to make an impact on somebody's life. I love the challenge and the opportunity that nursing provides me to do that. I believe that the reasons for the nursing shortage have been adequately analyzed and processed. I think it's time to go on with trying to solve the problem and developing and implementing long-term plans now.

I am listing several recommendations coming from the opinion that if something isn't done to assist the nurse practicing at the bedside, the shortage will only get worse. Any changes that are made need to be long-term changes in the workplace where the nurse practices nursing.

Recommendation number one: Increased salaries. At present in the Philadelphia area, starting salaries are increasing fairly well; but unfortunately, the gap between starting salaries and maximum salaries is getting smaller and smaller.

I think you need to show the nurses who have put in time, experience, their own time to get education and certification, and you need to reward them with higher salaries.

Recommendation number two: Staff nurses make life and death decisions every day, yet they have little or no say in the policies and practices of the institution they work in as it affects the nurse and the patient. It is long overdue for including staff nurses in all levels of policy making and in decisions that affect their practice. This would include flexible working hours, employee benefits, working with support services to obtain more assistance in patient care and many, many other things.

Number three is related to the second recommendation. A change in administrative management styles and structure, the

theories of shared governance and participatory management should be implemented. Staff nurses are great problem solvers if they are only given the time and the resources and the proper management support.

Give us a chance to show what we could do to make patient care better. Thank you

[The prepared statement of Marie W. follows:]

TEXT OF TESTIMONY GIVEN TO SENATOR JOHN HEINZ
APRIL 6, 1988
BY MARIE W., RN, CCRN
STAFF NURSE/CHARGE NURSE INTENSIVE CARE

INTRODUCTION

I would like to express my appreciation for being asked to testify today about a topic that is of great importance to me and many of my collegues, the effect of the nursing shortage on patient care in the acute care setting.

WHAT DOES A NURSE DO

In order to fully understand what nursing care services are not being provided due to lack of nurses, I would like to discuss what it is that I do as a nurse taking care of patients in an intensive care unit. The following scenario is typical of an average workday in an ICU when there is enough registered nurses and enough support personnel to assist the nurse in providing nursing care.

It is 7 AM in the ICU. I have just been assigned to provide care for two patients, John and Arlen.

For the first half hour of my shift, I receive report from the nurse who provided care for John and Arlen for the last eight hours. The nurse starts by relating each patient's medical history; what their major physical problem is; all other medical and surgical problems, resolved, and/or unresolved; what tests and treatments the patients have received or will receive, and how they have responded to these tests and treatments both physically and emotionally; any family members that have visited or phoned, and how they are dealing with the serious illnesses of their family member; how we are providing the basic human needs of air, water, nutrition to each patient; any problems with the complex monitoring systems that we use each day, and any other pertinent information I need that will influence the nursing care that I provide.

I then stop in to see each patient to make sure they are alive and not in any acute distress, and let them know I will be back shortly to do a more complete exam.

Next I check to see what medications and intravenous fluid each patient is receiving and when they are scheduled to be given. I look up any medications that I don't know, for I am responsible for knowing how each medication works in the body, desired effects, possible interactions with other medications and foods, and possible mild and life-threatening complications that could develop. I prepare the medications and intravenous fluids for each patient and administer them throughout the day as scheduled.

I check any lab tests or other test that have been performed recently to analyze the results, and if there are any abnormalities, and report these to the doctor, and initiate any other nursing actions that may be needed. For example, if a patient's blood glucose is 10, he could immediately develop seizures and die. As soon as I find out the lab results, I would administer intravenous glucose with or without a doctor present, because the patient's life is in danger.

I walk into John's room, walk over to the bed, reach out for his hand and introduce myself. I then ask John how he was feeling, or how his night was. During that interaction with John, I am mentally looking for and processing alot of verbal and non-verbal information I am observing, such things as: how does John respond, or does he respond at all; does he look comfortable, or does he appear restless or agitated; is he having trouble breathing; is his forehead, or the rest of his body sweaty; is his skin color as it should be or is it pale, blue- or gray-tinged; what is the temperature of his hand and how does the pulse feel in that hand, if it is there at all. This interaction could take about 5 minutes or so. If there are any clues that look abnormal to me at this point I very quickly try to identify the cause of the abnormality in order to intervene to prevent further more serious physical problems from developing. If there are no identifiable problems at this point, I then start a complete physical exam of the patient being alert for any abnormalities or changes from previous examinations. After completing the exam I check all the equiptment in the room to make sure everything is in safe working order, to prevent injury to John, and to be prepared for any emergency that might develop. During this time, I am also talking to John and asking questions which will give me an indication of how much John knows about his illness, all the tests he has received and will receive, what treatments he has received and why we are doing them,

what medications he is receiving, why he is taking them, and what side effects he may experience, how he is coping with his illness, and being in an ICU, and how his family is coping. Last I tell him what he can expect to happen over the next few hours, and how he can help if he is well enough.

Next, I go into Arlen's room and go through the same routine, but still being alert for the subtle clinical signs of serious medical and emotional problems.

After gathering all the information I mentioned, I then formulate a plan of care for each patient for that day, in collaboration with the physicians responsible for the medical care of the patients.

The rest of my shift consists of providing nursing care for my patients, based on the definition that nursing is treating the patient's total response to his illness, physical, psychological, emotional, and spiritually. I start implementing the plan of care mentioned earlier that will aid in each patient getting well, adapting to his illness, and preventing any further complications that could occur. I would include plans for assisting John in changing his position in bed frequently, to help prevent serious complications of bed rest which include bed sores, blood clots which can form in the legs and travel to the lungs, and loss of function in his arms and legs. I would assist John in getting out of bed for the same reasons. I would help John with breathing exercises every one to two hours to prevent him from developing pneumonia which could prolong John's stay in the hospital for weeks, or could even cause his death.

All throughout the day as I perform the many skilled tasks that I do, I am constantly monitoring each patient's condition for changes, good or bad, and I initiate appropriate treatment as needed.

Sometime during the day, I document everything I observed, everything I did, and the patients responses to all the medical and nursing interventions performed that day.

At 3 PM I give report on both patients, similar to the one I received, but also including my observations, what my plan of care was, what actions I was able to initiate and what she could do to continue with that plan. At 3:30 PM I leave the hospital, reflecting on the busy day that I had, but generally satisfied that I was able to utilize all my knowledge and skills to provide the kind of nursing care to each of my patients that I can be proud of, and that makes me glad that I chose nursing as a profession.

NURSING CARE WHEN THERE ISN'T ENOUGH NURSES

What happens when there aren't enough nurses? First nurses establish priorities based on patients physical needs, similar to triaging that is utilized in emergency rooms. Anything life threatening gets taken care of first. In many cases the nurse is only able to provide this level of care due to the acute illnesses of most of the patients we treat. What is not getting done? Consider the following:

1. Monitoring the patients as frequently as needed- A patient who has had a head injury should be checked every hour but may only be checked every four hours. During that time significant problems can develop and treatment will be delayed.

2. Prevention of complications- Not being able to turn patients as much as they need, get them out of bed, clean up body fluids that if left on the skin can cause severe skin problems, changing dressings, intravenous lines and intravenous sites. Patients can develop life threatening infections if these proceedures are not performed as needed.

3. Patient education- on all aspects of the patient's illness, hospitalization, ways to identify medical problems, when to seek medical help, how to prevent a recurrance of the problem. Patients do not get much of this from most of the medical staff, and now they are not getting it from the nursing staff as much as needed. Patients then out of ignorance will develop medical problems again and need to be treated again.

4. Emotional support for the patient and the family- Studies have shown over and over again that stress can have an adverse effect on the duration and the severity of an illness. Nurses are so busy dealing with the acute manifestations of illnesses, they have little time to talk and provide emotional support for the patient and the family

Much research has documented that if nurses have the time to provide adequate nursing care that patients get out of the hospital faster, are in a better state of wellness when they leave, do not have as many long-term serious side-effects from their disease, and have enough information to prevent further reoccurance of their disease, or to minimize potential problems.

HOW BAD IS IT

I would like to give some examples of problems with providing safe nursing care in intensive care units.

#1

A nurse was assigned the care of two critically ill patients. Bothe of them had very unstable blood pressures. One patient had a very severe infection, his lungs weren't functioning , so he was on a respirator, his liver wasn't functioning, so he was slowly bleeding from many places because his liver couldn't make the clotting factors necessary to stop him from bleeding, he received numerous blood transfusions, was on three different potent medications to help raise his blood pressure(which weren't working too well), his blood sugars were being checked every hour because they were either too high or too low,. The first patient was on two potent medications for his blood pressure(which also weren't working well). He was agitated and tried to pull his IVs out(the ones that were administering the blood pressure medications.) This patient's room was a pretty fair distance from the other patients requiring alot of running between rooms. Each of these patients should have had one nurse each according to the nursing care classification system used to determine how many nurses are needed for each patient. There were no other nurses who could help and no other nursing personnel available to assist this nurse. Throughout the day in order to make a decision on what to do next, the nurse had to decide who would suffer the most harm if a certain task or test could not be done, because it all needed to be done, but it was impossible to get it done.

#2

A nurse(A) was responsible for providing care for two patients who were very critically ill. Another nurse(B) was in the same area of the unit also had two patients who were very ill. Nurse A spent part of her time taking care of one of nurse B's patients, because the other patient was so unstable for the first five hours of the shift. Nurse B went to the nurses lounge at 1:30 in the afternoon to wolf down her lunch in ten minutes. While at lunch, Nurse A was putting one of Nurse B's patients back in the chair she was tipping over, when the EKG alarm for another patient started to alarm, and continued to alarm for the two or three minutes it took to put the patient back into the chair. The nurse then checked to see who was alarming- it was Nurse B's other patient, whose heart had stopped beating and she had stopped breathing. At the time of the code Nurse A was the only body present within shouting distance. She had to scream for help three times before anyone heard her. The patient never survived.

CONCLUSIONS

Nurses are in very precarious positions from a legal and ethical standpoint-they know it-that's one of their reasons for leaving. Patients are suffering more complications, are in the hospital longer, are coming back more frequently, and possibly dying because nurses don't have the time to do what they know they have the knowledge and skill to do, due to inadequate staff.

Nurses will continue to leave the bedside if day after day they are placed in situations where they know they are not able to provide adequate nursing care. They are getting burned out from doing constant crisis-intervention type of nursing, and they are constantly afraid of losing their licenses to practice, because they know what they can't get done.

RECOMMENDATIONS

I am listing several recommendations, coming from the opinion that if something isn't done to assist the nurse practicing at the bedside, the shortage will only get worse. Any changes that are made need to be long term changes in the way nurses practice nursing and in the workplace where they practice nursing.

1. Salary increases: especially increase the small gap between starting and maximum salaries. Also have some element of merit increases based on performance, experience, and certification in a specialty.

2. Staff nurses make life and death decisions every day, yet they have little or no say in the policies and practices of the institution they work in, as it affects the nurse. It is long overdue for including staff nurses in all levels of policy making, and in decisions that affect their practice. This would include flexible working hours, employee benefits, working with support services to obtain more assistance in patient care.

3. Related to the second recommendation- Change in administrative management styles and structure- Shared goverance, participatory management- Nurses are great problem solvers, if only given the time and the resources, and the proper management support.

Thank you.

Senator HEINZ. Marie, thank you very much. I particularly appreciate you and our next witness for being willing to come and give us a view of what it's like in the trenches, and you have done so, and I am deeply grateful to you.

Let me ask our next witness, Joann, to please proceed. Joann.

STATEMENT OF JOANN B., R.N.

Ms. JOANN B. My name is Joann. I've been a registered professional nurse for almost 12 years. In my current position as a staff nurse in the IV Therapy Department, I have the opportunity to treat patients in all areas of the hospital. Although each patient care unit lends itself to particular disease entities, a basic problem is common to all—not enough nurses.

I'm sure everyone is aware that people are living longer and that this is a result of advanced technology, treatments and complex medications. But is everyone aware of the impact this has on the registered nurse in the hospital setting? Approximately half of the patients we care for are 60 years of age or over. We are seeing them in acute phases of chronic illness; chronic lung disease, cardiovascular illness; renal failure, et cetera. These patients do not have the stamina, the skin integrity or the immune system of individuals in their 30's or 40's. Therefore, they require more skilled nursing care than ever before. Ten years ago a nurse could handle 10 to 12 patients. With today's spiral of technology, it can be difficult to care for 6 patients.

On a typical medical surgical unit, it is not uncommon for a nurse to have the responsibility for as many as 10 patients. Obviously, in an 8-hour shift, a nurse cannot give each patient 1 hour of her time. There is little time, if any, to assess a patient's condition, read charts, make rounds with physicians, devise a plan of care to include discharge preparation, let alone implement the plan. Time for patient and family teaching is at a minimum. With the onset of DRG's the emphasis is on decreasing the length of hospital stays. We refer to this as "move'um in, move'um out." The nursing responsibilities as mentioned become crucial.

A good example of this is the newly diagnosed diabetic patient. This individual needs nursing intervention. He needs the nurse to calm his fears, to be assured that although his life style may be somewhat changed, he can still be as productive as before. He needs to understand his disease process and the potential complications of that process. He needs instruction in diet, how to administer insulin, how to monitor his blood sugar levels at home, and be able to adjust his insulin dose accordingly. This is the responsibility of the registered nurse. Without this nursing intervention, this patient will have subsequent hospital admissions.

With the current staffing shortage in hospitals, nurses revert to "no frills" care. Nursing supervision tells us to do the best you can with the staff available. The adrenalin flows, you quickly set your priorities and keep plugging. Most often, you cannot provide the quality of care you'd like to. You try to maintain safe standards.

In a recent discussion with a manager of risk management, we were told that if the nursing unit is short staffed on Monday, that is not dangerous; it is exhaustive. Short again on Tuesday is still

exhaustive. However, if you're short again on Wednesday, then it can become dangerous. Further, that if you keep the IV's running, give the necessary medications and tube feedings on a comatose patient, but are unable to give bedside physical therapy and the patient ends up with contractures, that isn't quality, but the patient is alive, so that's safe. But we ask, did the patient suffer?

Nursing and Hospital Administrators are generally sympathetic to the nursing shortage. They respond by hiring agency or per diem nursing. We refer to this as rent-a-nurse, similar to rent-a-car. The money required to pay these nurses and their respective agencies is overwhelming. It cuts into already overextended budgets. These agencies are growing rapidly. More and more nurses are joining them because they choose when and where they work for anywhere between $22 to $30 per hour. More important, if they have an overwhelming day today, they won't have to face it again tomorrow. They are not members of the hospital nursing staff.

I would like to provide you with a few incidents that may further illustrate what I have presented today.

Picture an emergency room with six critically ill intensive care patients waiting for intensive care unit beds, which are at this point unavailable. There are empty beds, but not enough nursing staff available in those units to care for any more patients at that time. Four of these patients are on special intravenous drips that require vital signs to be taken every 5 to 10 minutes. Two of these patients are on ventilators.

I'd like to add at this point that the four patients who were not on ventilator beds were pushed into the hallway on portable monitors so that the nurses could see them as they ran by.

Seven patients with assorted problems are there waiting to be admitted to beds on regular medical surgical units. Some have been there since the day before.

One code is currently in progress, a patient who is in cardiac arrest.

Two trauma patients are waiting to go to the operating room, stab wounds, a gun shot.

A local psychiatric patient keeps coming into the emergency room and has to be escorted out. She finally gets past security, runs into a bathroom with a broken piece of glass, cuts her wrists and is now being chased through the emergency room by the guards with her blood dripping.

In the midst of all this, there is a line of physicians standing in the center of the emergency room with their arms folded facing a group of hospital administrators whose arms are also folded. It looked like the stand off at the OK Corral. The physicians are demanding the emergency room be closed. The administrators are saying, no. A nurse says "Don't just stand there with your arms folded. Pitch in and help or go someplace else."

Another trauma rolls in, a child with head injuries. The physicians win, the emergency room is closed. It's 11 o'clock in the morning.

There were only six nurses. How many vital signs could be taken, how much documentation could be done, how many medications were given as ordered?

Now, picture an intensive care unit, 3 p.m. to 11 p.m. shift. There are eight patients and five nurses. One nurse has two patients, one of which should be a "one to one", but staffing doesn't permit. We'll refer to that patient as Mrs. Smith. The other patient appears to be more stable. She had surgery that day. We'll call her Mrs. Jones.

The nurse enters Mrs. Jones' room and hangs an IV antibiotic and then returns to Mrs. Smith whose condition is deteriorating. Mrs. Jones begins to flush, her heart rate goes up to 120, she is having a reaction to the antibiotic, her alarm goes off making her more frightened. She rings for her nurse, but the nurse is so involved with Mrs. Smith she doesn't see the light. Mrs. Jones begins to cry out for help. The nurse hears her and runs into the room. She quickly assesses the situation, discontinues the medication and calls the physician. Mrs. Jones survived but suffered permanent damage to her heart muscles.

A basic surgical unit, day shift.

Mr. Brown is a chronically ill cancer patient, back again after many admissions. He asks the nurse to help him walk to the bathroom; he is too weak to go alone. The nurse asks if he can wait a few minutes and then she'll be able to help him. Mr. Brown says he can wait. The nurse has nine other patients. She prepares one patient for the operating room, hangs a fresh intravenous on another. She helps another patient on and off the bedpan. She hears a crash. Mr. Brown didn't wait any longer. He thought he would try to go himself. He knows his nurse is busy. He fell, and in the process dislocated his shoulder and fractured his hip.

The IV nurse team.

The IV therapy department has been cut back several times due to budget restraints. Now there are only four nurses to cover 16 hours a day 7 days a week. Many times there is only one nurse for an entire 8-hour shift. The team tries to maintain Center for Disease Control (CDC) standards and hospital protocol changing all peripheral IV sites every 72 hours to prevent phlebitis, infection, infiltration. But with an average of 150 IV's running per day on just the medical surgical units, it's impossible. The team cannot change all the IV sites and start new IV lines on the admissions, patients having tests or surgery, or those needing blood transfusions or chemotherapy. The team does its best, but many IV sites remain unchanged, sometimes as long as 6 days instead of the 3 days as recommended.

Thank you.

[The prepared statement of Joann B., R.N., follows:]

Text of Testimony Given To
U.S Senate Special Committee on Aging
6, April 1988
by Joann B., RN

My name is Joann I have been a Registered Professional Nurse for almost 12 years. In my current position as a staff nurse in the IV therapy department. I have the opportunity to treat patients in all areas of the hospital. Although each patient care unit lends itself to particular disease entities: a basic problem is common to all - not enough nurses.

I'm sure everyone is aware that people are living longer and that this is a result of advanced technology, treatments and complex medications. But everyone is aware of the impact this has on the Registered nurse in the hospital setting. Approximately, half of the patients we care for are 60 years of age and older. We are seeing them in acute phases of chronic illness; chronic lung disease, cardiovascular disease, renal failure etc.. These patients do not have the stamina, the skin integrity or the immune system of individuals in their 30's or 40's. Therefore they require more skilled nursing care than ever before. Ten years ago a nurse could handle 10-12 patients, with today's spiral of technologyit can be difficult to care for 6 patients.

On a typical medical surgical unit it is not uncommon for a nurse to have responsibility for as many as ten patients. Obviously in an 8 hour shift a nurse can not give each patient 1 hour of her time. There is little time if any to assess a patients condition, read charts, make rounds with physicians, devise a plan of care to include discharge preparation, let alone implement that plan. Time for patient and family teaching is at a minimum. With the onset of DRG's the emphasis is on decreasing the length of hospital stays,(we refer to this as "move 'um in move 'um out), the nursing responsibilities as mentioned become crucial.

A good example of this, is the newly diagnosed diabetic patient. This individual needs nursing intervention. He needs the nurse to calm his fears, to be assured that although his life style may be somewhat changed he can still be as productive as before. He needs to understand his disease process and the potential complications of that process. He needs instrution in diet, how to administer insulin, how to monitor his blood sugar levels at home, and be able to adjust his insulin dose accordingly. This is the responsibility of the Registered nurse. Without this nursing intervention this patient will have subsequent hospital admissions.

With the current staffing shortage in hospital, nurses revert to "no frills" care. Nursing supervision tells us to do the best you can with the staff available. The adrenalin flows, you quickly set your priorities and keep plugging. Most often you cannot provide the quality of care you'd like to, you try to maintain "safe" standards. In a recent discussion with a manager of Risk Management we were told that if the nursing unit is short staffed on Monday that is not dangerous it is exhaustive, short again on Tuesday is still exhaustive, however, if your are short again on Wednesday, then it can become dangerous. Further that if you keep the IV's running, give the necessary medications and tube feedings on a comatose patient, but are unable to give bedside physical therapy and the patient ends up with contractores, that isn't qualtiy but the patient is alive so that's safe. But we as, did the patient suffer?

Nursing and Hospital Administrators are generally sympathic to the nursing shortage. They respond by hiring agency or perdiem nursing We refer to this as "rent an nurse", similare to rent-a-car. The money required to pay these nurses and their respective agencies is overwhelming. It cuts into already over extended budgets. These agencies are growing rapidly. More and more nurses are joining them, because they choose when and where they work for anywhere between $22.00 to $30.00 per hour. MOre important, if they have an overwhelming day today, they won't have to face ti again tommorrow. They are not members of the hospital nursing staff.

I would like to provide you with a few incidents that may further illustrate what I have presented today.

Picture an emergency room with:

6 critically ill intensive care patients waiting for intensive care unit beds, which are at this point unavailable. (There are empty beds - but not enough nursing staff available in those units to care for anymore patients at that time). 4 of these patients are on special intravenous drips that require vital sighs to be taken every five to ten minutes, two of these patients are on ventilators.

7 patients with assorted problems are there waiting to be admitted to beds on regular medical surgical units - some have been ther since the day before.

1 code is currently in progress - a patient who is in cardiac arrest.

2 trauma patients waiting to go to the operating room, stab wounds, a gun shot.

A local psychiatric patient keeps coming into the emergency room and has to be escorted out. She finally gets past security, runs into a bathroom with a broken piece of glass, cuts her wrist and is now being chased through the emergency room by the guards with her blood dripping.

In the midst of all this there is a line of physicians standing in the center of the emergency room with there arms folded, it looked like the stand off at the "OK corral." The physicians are demanding the emergency room be closed the administrators are saying no. A nurse says "don't just stand there with your arms folded pitch in and help or go someplace else."

Another trauma rolls in, a child with head injuries. The physicians win, the emergency room is closed. It's 11:00 in the morning. There were only 6 nurses. How many vital signs could be taken, how much documentation could be done, how many medications were given as ordered?

Now picture an intensive care unit 3pm to 11pm shift. There are 8 patients and 5 nurses. One nurse has 2 patients, one of which should be a "one to one" but staffing doesn't permit, we'll refer to that patient as Mrs. Smith. The other patient appears to be more stable she had surgery that day, we'll call her Mrs. Jones. The nurse enters Mrs. Jones room and hangs an IV antibiotic then returns to Mrs. Smith whose condition is deteriorating. Mrs. Jones begins to flush, her heart rate goes up to 120, she is having a reaction to the antibiotic, her alarm goes off making her more frightening she rings for her nurse, but the nurse is so involved with Mrs. Smith she doesn't see the light. Mrs. Jones begins to cry out for help. The nurse hears her and runs into the room. She quickly accesses the situation, discontinues the medication and calls the physician. Mrs. Jones survived but suffered permanent damage to her heart muscles.

A basic surgical unit - day shift

Mr "Brown" is chronically ill cancer patient, back again after many admissions. He asks the nurse to help him walk to the bathroom, he is too weak to go alone. The nurse asks if he can wait a few minutes and then she'll be able to help him. Mr. Brown says he can wait. The nurse has 9 other patients. She prepares one patient for the operating room, hangs a fresh intravenous on another. She helps another patient on and off the bedpan, she hears a crash. Mr. Brown didn't wait any longer he thought he would try to go himself, he knows his nurse is busy. He fell, and in the process dislocated his shoulder and fractured his hip.

The IV nurse team:

The IV therapy department has been cut back several times due to budget restraints. Now there are only four nurses to cover 16 hours a day, 7 days a week. Many times there is only one nurse for an entire 8 hour shift. The team tries to maintain Center for Disease Control (CDC) standards and hospital protocal changing all peripheral IV sites every 72 hours to prevent phlebitis, infection, infiltration. But with an average of 150 IV's running per day on just the medical surgical units it's impossible. The team cannot change all the IV sites, and start new IV lines on the admissions, patients having tests or surgery, or those needing blood transfussions or chemotherapy. The team does it's best, but many IV sites remain unchanged, sometimes as long as 6 days instead of the 3 days as recommended.

Senator HEINZ. Thank you, Joann.

That sounds like a very tough day at the office. Thank you for those insights. I will have questions for both you and Marie in a few minutes, but I want to hear from the rest of our first panel.

. Dick Loughery is special assistant to the Secretary of Health and Human Services. And Dick, please proceed.

STATEMENT OF RICHARD LOUGHERY, SPECIAL ASSISTANT TO THE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LOUGHERY. My name is Richard Loughery. From 1946 until 1985, I worked in the private sector in the field of hospital management. In January 1986 when Secretary Otis Bowen came to Washington, he asked me to join his staff as a special assistant. Since the mid-1980's, I have been hearing from many of my former colleagues all across the country who were noting the difficulty of nurse staffing in their hospitals. Some previously published national reports stated that all things being equal, there would be an ever-increasing number of nurses up until the year 2000. Thus, many people would not accept the concern of nursing employers that vacancies seem to be increasing and harder to fill than in past years.

Investigations show that all things were not equal, and there were primary reasons for the situation.

One was the supply of new graduates from the schools of nursing is reducing in numbers; and second, the number of nurses needed to take care of hospital patients has increased markedly for several years.

There are several other reasons which exacerbate these two prime factors. I'd like to take this opportunity to bring you up to date on where the department stands in addressing these issues.

Senator HEINZ. Dick, if I might interrupt at this point.

Mr. LOUGHERY. Yes, sir.

Senator HEINZ. It was your idea that the Secretary form a Commission on Nursing; is that not right?

Mr. LOUGHERY. Yes, sir.

Senator HEINZ. And you are very involved with that Commission, you are looking into that question, and you anticipate making a report later this year?

Mr. LOUGHERY. Yes, sir. It would be an interim report in May and a final in December.

Senator HEINZ. Very well, I just wanted to get that clear on the record. Thank you. Please proceed.

Mr. LOUGHERY. Since some observers believe that Federal health care financing policies, particularly prospective payment in hospitals, have an impact on the nursing situation, the Secretary has asked that our two major agencies, HCFA and Public Health Service, need to examine the relationships between Medicare reimbursement and the nursing shortage.

The department will continue the nursing student loan program which provides loans at reduced interest rates for nursing students who have great financial need.

In August we redistributed $10 million to new and existing schools in need of additional loan capital. In total there's $18 million available for student loans.

The department also will continue to conduct research and collect data on nursing issues. For example, the National Center on Nursing Research, which is the newest institute at NIH, sponsored a national invitational workshop on the nursing shortage this February, and is sponsoring another survey this year of all registered nurses.

In addition, the Health Care Financing Administration has funded the studies which examine the relationship between nursing care requirements and the Medicare payment system.

As a final point, and of great significance, the Secretary did convene a group of national nurse leaders and employers last September. The consensus was that there needed to be a study made of the reason for the shortage and recommendations which would lead to the correction of the problems. They additionally agreed that the implementation should be a public/private responsibility. Thereafter, the Secretary formed the Commission with public and private membership to provide advice and recommendations. The Secretary's Commission meets in Washington every month, has held hearings in Chicago, San Francisco, and yesterday in New Orleans.

The Commission has yet to provide the Secretary with the preliminary report on the issues, and the department has not had the opportunity to review the findings. Upon receipt of the Commission's preliminary report sometime in May, we will evaluate the findings and any recommendations.

We certainly appreciate the Congress' interest in this area. However, we do caution against seeking a simple solution to a very, very complex issue. Thank you.

Senator HEINZ. Thank you, very much, Mr. Loughery. We appreciate—were you in New Orleans yesterday?

Mr. LOUGHERY. No, sir. I was trying to get here and missed my train.

Senator HEINZ. Thank you for coming, and I'm sorry you missed your train. From Washington or from New Orleans?

Mr. LOUGHERY. No. From Washington, oddly enough.

[The prepared statement of Mr. Loughery follows:]

"VANISHING NURSES - DIMINISHING CARE"
HEARING BEFORE U.S. SENATE COMMITTEE ON AGING
SENATOR JOHN HEINZ, RANKING MEMBER - PRESIDING
PHILADELPHIA, PENNSYLVANIA - APRIL 6, 1988

MY NAME IS RICHARD LOUGHERY. FROM 1946 UNTIL 1985 I WORKED IN THE PRIVATE SECTOR IN THE FIELD OF HOSPITAL MANAGEMENT. IN JANUARY OF 1986, DR. OTIS BOWEN, THE SECRETARY OF HEALTH AND HUMAN SERVICES ASKED ME TO JOIN HIS STAFF AS A SPECIAL ASSISTANT.

SINCE THE MID 1980S, I HAVE BEEN HEARING FROM MANY OF MY FORMER COLLEAGUES ALL ACROSS THE COUNTRY WHO NOTED THE DIFFICULTY OF NURSE STAFFING IN THEIR HOSPITALS. SOME PREVIOUSLY PUBLISHED REPORTS STATED THAT, ALL THINGS BEING EQUAL, THERE WOULD BE AN EVER INCREASING NUMBER OF NURSES UP UNTIL THE YEAR 2000. THUS, MANY PEOPLE WOULD NOT ACCEPT THE CONCERN OF NURSE EMPLOYERS THAT VACANCIES SEEMED TO BE INCREASING AND HARDER TO FILL THAN IN PAST YEARS. INVESTIGATION SHOWED THAT ALL THINGS WERE NOT EQUAL AND THERE ARE TWO PRIMARY REASONS FOR THE SITUATION. ONE WAS THAT THE SUPPLY OF NEW GRADUATES FROM SCHOOLS OF NURSING IS REDUCING IN NUMBER, AND SECOND, THE NUMBER OF NURSES NEEDED TO TAKE CARE OF HOSPITAL PATIENTS HAS INCREASED MARKEDLY FROM SEVERAL YEARS AGO. THERE ARE SEVERAL OTHER REASONS WHICH EXACERBATE THESE TWO PRIME FACTORS.

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO BRING YOU UP TO DATE ON WHERE WE NOW STAND IN ADDRESSING THESE ISSUES.

SINCE SOME OBSERVERS BELIEVE THAT FEDERAL HEALTH CARE FINANCING POLICIES -- PARTICULARLY PROSPECTIVE PAYMENT FOR HOSPITALS-- HAVE AN IMPACT ON THE NURSING SITUATION, THE SECRETARY HAS ASKED THAT OUR TWO MAJOR HEALTH AGENCIES, THE HEALTH CARE FINANCING ADMINISTRATION AND THE PUBLIC HEALTH SERVICE, EXAMINE THE RELATIONSHIP BETWEEN MEDICARE REIMBURSEMENT AND NURSING SHORTAGES.

THE DEPARTMENT WILL CONTINUE THE NURSING STUDENT LOAN PROGRAM, WHICH PROVIDES LOANS AT REDUCED INTEREST RATES FOR NURSING STUDENTS OF EXCEPTIONAL FINANCIAL NEED. WE REDISTRIBUTED $10 MILLION TO NEW AND EXISTING SCHOOLS IN NEED OF ADDITIONAL LOAN CAPITAL. IN TOTAL, APPROXIMATELY $18 MILLION IS AVAILABLE FOR NURSING STUDENT LOANS.

THE DEPARTMENT ALSO WILL CONTINUE TO CONDUCT RESEARCH AND COLLECT DATA ON NURSING ISSUES. FOR EXAMPLE, THE NATIONAL CENTER ON NURSING RESEARCH SPONSORED A NATIONAL INVITATIONAL WORKSHOP ON THE NURSING SHORTAGE IN FEBRUARY, AND IS SPONSORING A NATIONAL SURVEY THIS YEAR OF REGISTERED NURSES. IN ADDITION, THE HEALTH CARE FINANCING ADMINISTRATION HAS FUNDED STUDIES WHICH EXAMINE THE RELATIONSHIP BETWEEN NURSING CARE REQUIREMENTS AND THE MEDICARE PAYMENT SYSTEM.

AS A FINAL POINT, BUT OF THE GREATEST SIGNIFICANCE, SECRETARY BOWEN CONVENED A GROUP OF NATIONAL NURSE LEADERS AND EMPLOYERS LAST SEPTEMBER. THE CONSENSUS WAS THAT THERE NEEDED TO BE A STUDY MADE OF THE REASONS FOR THE SHORTAGE AND RECOMMENDATIONS MADE WHICH WOULD LEAD TO THE CORRECTION OF THE PROBLEMS. THEY ADDITIONALLY AGREED THAT IMPLEMENTATION OF THE RECOMMENDATIONS SHOULD BE A PUBLIC-PRIVATE RESPONSIBILITY.

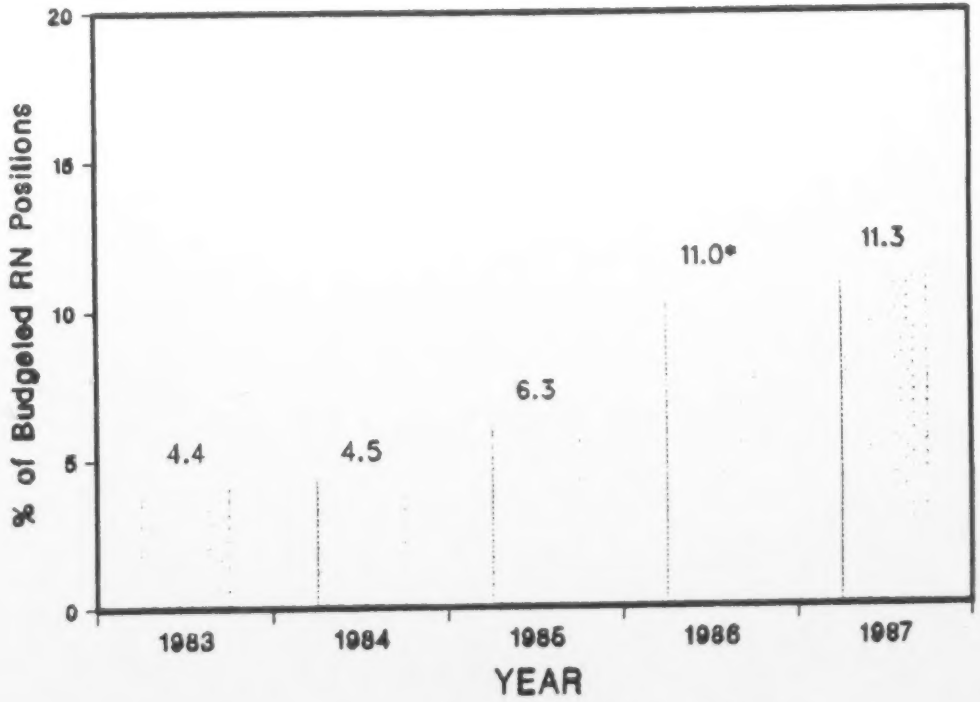
THEREAFTER, THE SECRETARY FORMED A SPECIAL COMMISSION ON NURSING WITH PUBLIC AND PRIVATE MEMBERSHIP TO PROVIDE ADVICE AND RECOMMENDATIONS ON THE NURSING SITUATION. THE SECRETARY'S COMMISSION MEETS IN WASHINGTON EVERY MONTH, HAS HELD HEARINGS IN CHICAGO, SAN FRANCISCO, AND YESTERDAY IN NEW ORLEANS. AN INTERIM REPORT IS DUE TO THE SECRETARY IN MAY AND A FINAL IN DECEMBER OF THIS YEAR.

THE COMMISSION HAS YET TO PROVIDE THE SECRETARY WITH A PRELIMINARY REPORT ON THIS ISSUE AND THE DEPARTMENT HAS NOT HAD THE OPPORTUNITY TO REVIEW THESE FINDINGS. UPON RECEIPT OF THE COMMISSION'S PRELIMINARY REPORT, DUE SOMETIME IN MAY, WE WILL EVALUATE THE FINDINGS AND ANY ACCOMPANYING RECOMMENDATIONS.

WE APPRECIATE THE CONGRESS' INTEREST IN THIS AREA; HOWEVER, WE CAUTION AGAINST SEEKING A SIMPLE SOLUTION TO THIS VERY COMPLEX ISSUE.

A

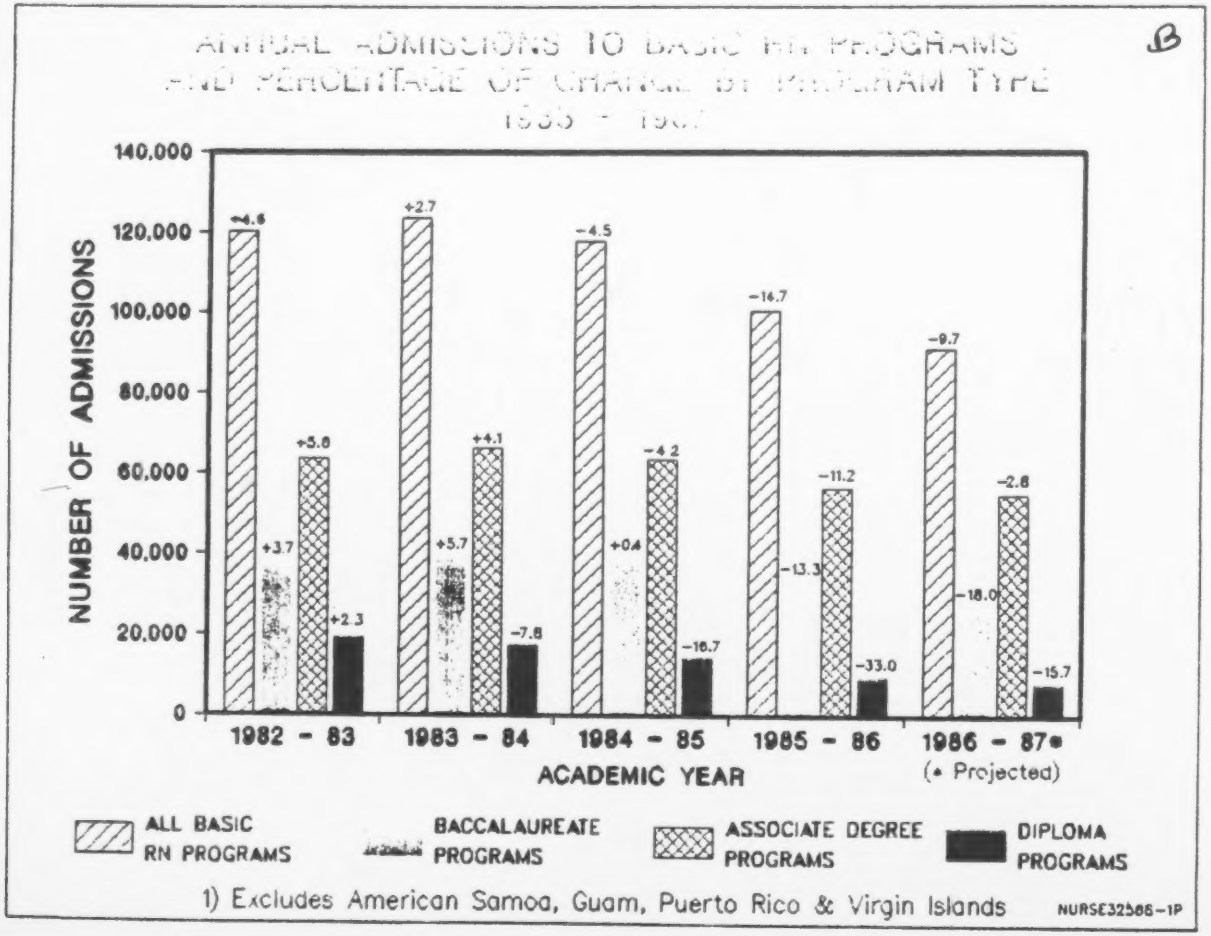
HOSPITAL RN VACANCY RATES



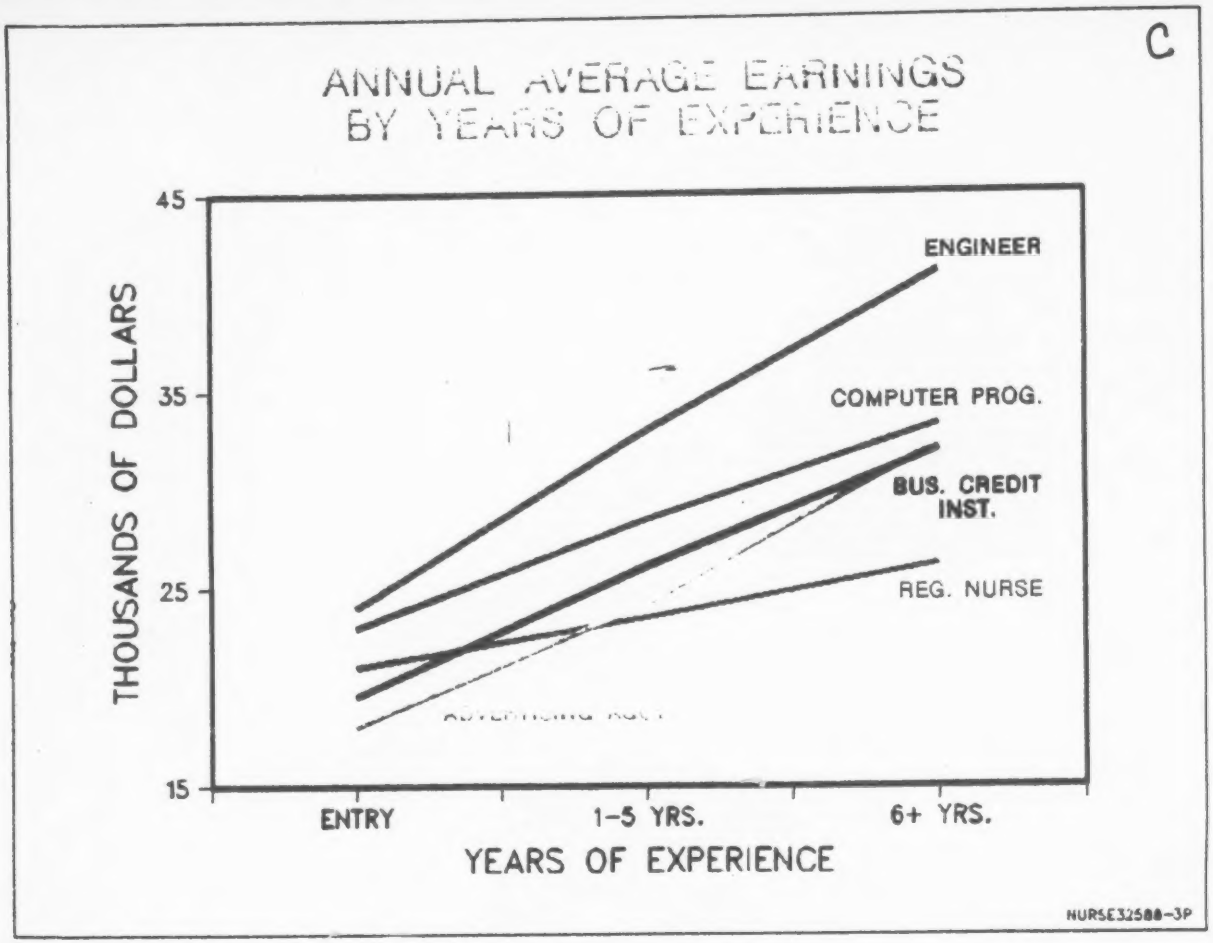
* The average vacancy rate of 11% increased to 13.6% when "outlier" data from four hospitals with large vacancy rates were added to the calculation

NURSE32588-2P

B


ANNUAL ADMISSIONS TO BASIC RN PROGRAMS
AND PERCENTAGE OF CHANGE BY PROGRAM TYPE
1983 - 1987
NUMBER OF ADMISSIONS
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
+4.6
+3.7
+5.8
+2.3
+2.7
+5.7
+4.1
-7.8
-4.5
+0.4
-4.2
-16.7
-14.7
-13.3
-11.2
-33.0
-9.7
-18.0
-2.8
-15.7
1982 - 83
1983 - 84
1984 - 85
1985 - 86
1986 - 87*
(* Projected)
ACADEMIC YEAR
ALL BASIC RN PROGRAMS
BACCALAUREATE PROGRAMS
ASSOCIATE DEGREE PROGRAMS
DIPLOMA PROGRAMS
1) Excludes American Samoa, Guam, Puerto Rico & Virgin Islands
NURSE32586-1P

C


ANNUAL AVERAGE EARNINGS
BY YEARS OF EXPERIENCE
45
35
25
15
THOUSANDS OF DOLLARS
ENGINEER
COMPUTER PROG.
BUS. CREDIT INST.
REG. NURSE
ENTRY
1-5 YRS.
6+ YRS.
YEARS OF EXPERIENCE
NURSE32588-3P

Senator HEINZ. Our last witness on this panel is Patricia Prescott. Patricia is a nurse educator from the University of Maryland. Patricia, please proceed.

STATEMENT OF PATRICIA PRESCOTT, BSN, PH.D., UNIVERSITY HOSPITAL, UNIVERSITY OF MARYLAND

Ms. PRESCOTT. Thank you.

Nursing shortages are a cyclic and chronic problem. Data suggest the current shortage is much the same as that in the early 1980's except for one critical difference, falling nursing school enrollments. Enrollments have been decreasing since 1983–84, and these declines, 5.3 percent in 1984, 8.1 percent in 1985, 11.1 percent in 1987, are expected to accelerate in the foreseeable future.

Falling enrollments and declining ability levels of those entering nursing indicate there will be substantially fewer nurses and they will have less rather than more ability than do those in the existing pool.

In the present situation, we are moving toward a dynamic labor market shortage where the falling enrollments, if they continue, will produce an imbalance in supply and demand.

There are two types of shortage, equilibrium and dynamic, and nursing has experienced both. Equilibrium shortages, such as we experienced in 1980, result when nurse labor markets are not fully competitive; that is, they are oligopsonistic. In oligopsonistic markets, a few employers, in this case hospitals, dominate the market, and wages do not freely rise to balance supply and demand. Employers often want a greater supply of nurses than prevailing wages will purchase.

Although economic theory suggests different responses toward different types of shortage, the Federal posture toward nursing shortages has been the same regardless of whether the shortage was of the dynamic or equilibrium type. Efforts to address the problem have been through money to subsidize nursing education with the intent of increasing the supply of nurses entering the labor market.

While nursing education is in need of Federal support to increase the proportion of basic practitioners prepared at the Baccalaureate level and increase the percentage of nurses with graduate education, subsidizing basic nursing education has not solved shortage problems in the past. In fact, when the shortage is primarily of an equilibrium type with artificially constricted salary levels, a focus on increasing the supply may actually make the problem worse by further suppressing wages, which in a properly functioning market would rise to attract new recruits to the occupation.

To correct equilibrium shortages, wages must be allowed to rise freely to balance supply and demand. To correct dynamic shortages, such as the one that may be developing as a result of falling enrollments, wages also must rise so that nursing is an attractive occupational choice relative to other options. With the declining pool of 18-year-olds and the ever-increasing number of attractive career options open to young people today in business, computer technology, law and medicine, the economic and psychic rewards of nursing will have to increase dramatically if we are to have an

adequate supply of nurses prepared to function in the technologically complex health care system.

Federal policies which encourage hospitals, as the dominant employers of 70 percent of the Registered nurses, to increase the economic and psychic rewards for nurses are needed. Rather than address the shortage primarily through the educational system, policies directly influencing the hospital labor market are needed. Given the concerns for cost containment, hospitals must be encouraged to internally reallocate resources.

At the present, many hospitals continue to lump nursing costs together with other costs in a room and board rate; and consequently, they have no clear understanding of how much nursing even costs. Identifying nursing costs as distinct from the room and board cost of hospitals is a needed step so that hospitals can institute variable billing for nursing services, and payors can identify the nursing care component in reimbursable services.

HCFA should be encouraged to require hospitals to collect and report data on nursing intensity and hours of nursing care delivered so that a national data base to establish nursing care costs can be developed. Identifying the true costs of nursing should lead to more efficient use of nurses in hospitals.

Encouraging hospitals to develop differentiated wage structures which reward nurses based on education and experience, and staffing patterns which use and pay nurses based on their level of practice, would address both the economic and psychic rewards for nursing. Major role restructuring of nursing within hospitals, with economic incentives attached to that restructuring is badly needed.

Today the differential between a beginning and an experienced nurse remains very thin, with staff nurses in practice 5 years or less averaging approximately $22,000 per year and nurses with 6 to 10 years experience averaging $25,000 a year and gaining very little thereafter.

Partial funding for these changes can be found by making the indirect costs associated with nursing educational programs eligible for Medicare passthrough support. At this time, indirect costs are allowed for medical but not for nursing education. While the total amount of Medicare passthrough support for nursing education is essentially unknown, it is thought to be approximately in the $200 to $300 million range.

According to the Congressional Budget Office, in fiscal 1987 medical education received $1.1 billion in direct and indirect subsidy. Given that the Nation has an established physician surplus and that nursing is moving toward a serious dynamic shortage, a more equitable distribution of passthrough moneys in support of nursing is warranted. Such moneys should be used to support graduate nursing education and to encourage a differentiated wage structure tied to education and experience and designed to increase hospital retention of nurses. Supporting nursing at the level of the hospital as well as through subsidy of nursing education will help correct problems in the delivery system which contribute to nursing shortages. In particular, use of Medicare Passthrough funds to encourage a differentiated wage structure will help assure that nurses with 10 years experience earn more than the new graduate.

Future trends point to an aging population with increasingly complex health care needs. The technology of care and its specialization are also increasing. Today's general hospitals are like the intensive care areas of 20 years ago, and the acuity level of patients in nursing homes now approximates that previously seen in hospitals. Data indicate that the number of intensive care days is on the increase while the number of routine care days is declining.

To competently meet future patient care needs, nurses require more and better focused education. In many acute care settings, nurses' aides and licensed practical nurses are not utilized because they do not have the skills needed. Currently many LPN's are being encouraged to seek the additional education needed to obtain registered nurse licensure. Federal support for such programs is needed until existing practitioners are upgraded.

However, retraining is more costly and less efficient than is initial training at entry level, and Federal support, especially for minorities, to enter nursing at the registered nurse level is needed. Currently approximately 8 percent of Registered nurses are minorities, predominantly black, and 18 percent of LPN's are from minority groups. Federal support for minorities to enter nursing as registered nurses will help prevent them from being sidelined into nonpromotable positions at the bottom of wage scales.

In closing, the existing pool of nurses is on the decline. The average age of licensed registered nurses is 39 years, and within the next 20 years, a large number of these nurses can be expected to retire. At this time, the number of new recruits entering nursing is decreasing in number and ability. Unless substantial changes with long-range impact on wages and working conditions are made to make nursing attractive in comparison with other occupational choices, there will be fewer nurses to care for an aging population with increasingly complex health care needs.

I'd like to add a more personal observation. For years hospitals have treated nurses much like disposable supplies rather than like a valuable resource to be developed and nurtured. Nurses have been underpaid, overworked, and their contribution to patient care has been devalued. Hospitals have used up nurses replacing burntout staff with bright new recruits each year. Nurses have tolerated these conditions in large part because they had few alternative options. That's no longer true. And to meaningfully address the roots of the nursing shortage, hospitals have to decide it's time to stop abusing nurses.

[The prepared statement of Patricia Prescott follows:]

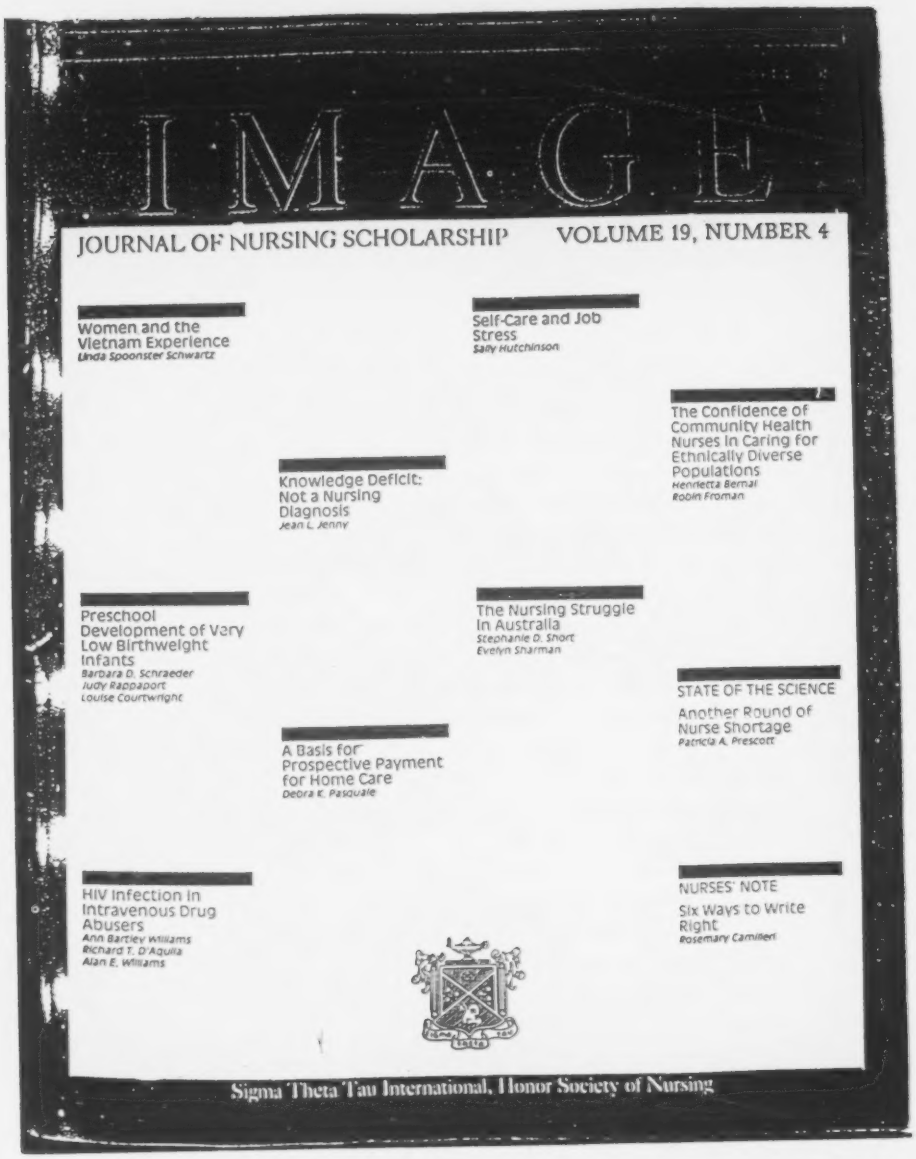


IMAGE
JOURNAL OF NURSING SCHOLARSHIP
VOLUME 19, NUMBER 4
Women and the Vietnam Experience
Linda Spoonster Schwartz
Self-Care and Job Stress
Sally Hutchinson
The Confidence of Community Health Nurses In Caring for Ethnically Diverse Populations
Henrietta Bernal
Robin Froman
Knowledge Deficit: Not a Nursing Diagnosis
Jean L. Jenny
Preschool Development of Very Low Birthweight Infants
Barbara D. Schraeder
Judy Rappaport
Louise Courtwright
The Nursing Struggle In Australia
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Evelyn Sharman
STATE OF THE SCIENCE
Another Round of Nurse Shortage
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A Basis for Prospective Payment for Home Care
Deora K. Pasquale
HIV Infection In Intravenous Drug Abusers
Ann Bartley Williams
Richard T. D'Aquila
Alan E. Williams
NURSES' NOTE
Six Ways to Write Right
Rosemary Camilleri
Sigma Theta Tau International, Honor Society of Nursing

State of the Science

Another Round of Nurse Shortage

Patricia A. Prescott

Interest in inadequate nurse staffing of hospitals waxes and wanes, and yet staffing appears to be a chronic problem. This persistent and often severe shortfall in the number of nurses has received considerable attention from at least two perspectives: economics and nursing. Efforts to reconcile the economic and professional views of nursing have been frustrated, in part because of the complex and fundamentally different conceptualizations of the problem and its solutions. Previous approaches to relieving shortages have relied heavily on recruitment of nurses from a large pool of new graduates. This reliance on recruitment without simultaneous concern for retention actually may have contributed only to making shortages worse.

This paper seeks to highlight the views of the economic and nursing perspectives and to apply key concepts from each toward an understanding of the nurse shortage in hospitals. The current situation is placed in the context of previous shortages, and the consequences of selected efforts to deal with nursing shortages in hospitals are discussed.

Economic Perspectives on Nurse Shortage

A shortage exists when the demand for something exceeds the supply available at a specific market price (Yett, 1975). The key terms are "supply," "demand," and "price," each of which has a precise meaning in economics. Supply, for example, refers to the number of available workers; demand is differentiated from want or need and refers to the employer's willingness to purchase a quantity of workers or services at a prevailing wage or price. Demand for hospital nursing services often is measured as budgeted, unfilled positions for which an employer is actively recruiting.

Basic to the economic perspective are assumptions regarding how markets operate, with price being inversely related to supply, and with supply, demand, price and employment level constantly adjusting toward equilibrium in a competitive market place. There are numerous economic models that depict these and other factors predictive of labor force participation (Feldstein, 1979; Schramm, 1982; Sloan, 1975; Sloan & Richupan, 1975; Yett, 1975).

It has been argued that the operation of nurse labor markets is not well explained by economic models. There are a number of reasons for this. Of particular importance to interpreting imbalances in supply and demand is the idea that the nurse labor market is not fully competitive because of monopsony or oligopsony. Monopsonistic or oligopsonistic market conditions exist when there are too few employers to stimulate meaningful wage competition. Under these conditions wages are artificially restrained, and they do not operate to balance supply and demand as in a freely competitive market. In a competitive market, when demand increases, so do wages to attract the needed supply. In an oligopsonistic market, however, wages are artificially set and do not freely rise in response to changes in demand. As Yett (1975) has demonstrated, under these conditions employers will express demand in excess of the supply that the prevailing wage will purchase; that is, they would like to hire more nurses, but they are not willing to raise wages sufficiently to do so. The excess demand is expressed as vacant positions that the employer wishes to fill at the prevailing wage. While full explanation of this phenomenon is beyond the scope of this paper, its importance lies in the fact that vacant positions may be in part an artifact of market conditions rather than a true indicator of a shortage.

Yett (1975) describes two types of nurse shortage: "equilibrium," resulting from oligopsonistic market constraints, and "dynamic," resulting from imbalances between supply and demand. This distinction is important because the appropriate solutions for the shortage depend in part on the type of shortage. In an equilibrium type of shortage, the logical solution is to remove wage constraints so that rising wages will balance supply and demand. Yett argues that the traditional approach to solving the nurse shortage has focused mistakenly on increasing the supply of new nurses entering the market. This approach may actually have increased the problem by further holding down wages, which normally would be expected to rise relative to other wages to attract new nurses into the labor market (Aiken & Blendon, 1981; Yett, 1975).

Others (Bognanno, Hixson & Jeffers, 1974; Sloan & Richupan, 1975) have argued that the nursing shortage is not caused primarily by depressed wages because of oligopsonistic markets. Instead, they attribute the shortage to geographic maldistribution, the functioning of local rather than national markets, the "inelastic" nature of the nurse market, and demographic factors predictive of labor force participation.

Within the economic perspective on nurse manpower there are a variety of models and viewpoints. While all are concerned with supply, demand, price and quantity of goods and/or services, there are few unambiguous conclusions that can be drawn. Whether or not the nurse market is oligopsonistic, economists have debated as to whether or not the market is inelastic (Sloan & Richupan, 1975). Some who suggest that nurse markets are inelastic argue that increasing wages for nurses only drives down the number of hours that nurses are willing to work. This explanation is based on the argument that the nurse market is relatively insensitive to wage changes (inelastic) (Bognanno, Hixson & Jeffers, 1974). It would mean that nurses determine the extent of their participation in the labor force more in terms of spouse income, age of children, and other sociodemographic factors than they do in terms of wages.

Despite their differences, economists share a global perspective concerned with the aggregate functioning of nurse markets. This perspective is important for determining policy, especially at the federal level. For example, the economic orientation of the Nurse Education Act, by subsidizing nursing education, has steadily increased the supply of Registered Nurses entering the market.

Economic theories and models used to study nursing manpower are useful for understanding the operation of national markets and shifts in the aggregate supply and/or demand. The-

PATRICIA PRESCOTT, R.N., Ph.D., Alpha Eta, is Professor and Chair of the Graduate Department of Psycho Physiological Nursing at the University of Maryland School of Nursing. Correspondence to School of Nursing, 655 W. Lombard Street, Baltimore, MD 21201.

Accepted for publication October 28, 1987.

ories and models developed using one unit of analysis, however, often are not directly transferable to another unit of analysis (Burnstein, 1980; Hannan, 1971; Herman & Hulin, 1972; Roberts & Burnstein, 1980; Rousseau, 1982). Thus predictors of labor force participation at the level of individual hospitals may not be useful in understanding nurse shortages at other levels of analysis such as at the aggregate national level. For example, turnover among nurses is often cited as a cause of nursing shortages. By definition, this is true at the institutional level since nurses who resign create vacant positions at that hospital. At the aggregate level, however, turnover does not explain nursing shortages unless nurses who leave their position in a particular hospital also leave the labor force for other occupations or join the inactive pool of nurses and hence withdraw from the market.

Turnover data suggest that the large majority of nurses who leave their jobs do not leave nursing; rather they take a similar job in another hospital, usually in the same local nurse market (Aiken, 1982; Weisman, 1982; Weisman, Alexander & Chase, 1981). Supporting this view are data from a study conducted from 1980 to 1984. Staff nurses who resigned from selected patient care units in 15 hospitals in various geographic regions of the country were interviewed by phone and asked to complete a brief questionnaire regarding both their reasons for resigning and their current employment status.[1] Of the nurses who participated, 89 percent ($N = 111$) were employed in some capacity in another hospital, and 8 percent were employed outside of the hospital but were still in nursing and hence were not lost to the labor market (Prescott & Bowen, 1987). This shows that turnover functions much like a revolving door at the aggregate level and therefore is not a cause of shortage at that level, as it is in institutions.

This lack of isomorphism of theories from one unit of analysis to another is important because administrators and others attempting to deal with institutional shortages often have applied the aggregate economic perspective to the strategies that they have pursued. In particular, many nurse and hospital administrators have assumed that turnover is both inevitable and beyond the control of hospitals because nurses' decisions about participation in the labor force are determined largely by sociodemographic factors beyond the hospital's control. This assumption has fostered "supply side" solutions to the shortage in hospitals as well as at the national level. The inevitability of turnover assumption is played out by focusing hospital efforts on recruitment of new nurses rather than on retention of existing staff members. Data indicate, however, that much turnover is not inevitable; nurses in the study actually gave more work-related than nonwork-related reasons for their resignations. Most frequently mentioned were scheduling factors—days, shifts and hours of work. Other factors in descending order of importance were problems with administrators, especially head nurses; a lack of stimulation and dissatisfaction with the practice of nursing; inadequate salary; poor nurse staffing; the desire for new experiences; and problems in staff interpersonal relationships (Prescott & Bowen, 1987).

The success of the approach that emphasizes recruitment over retention rests on four conditions: (a) a steadily available and increasing supply of new nurses; (b) economic conditions that make it less costly to replace rather than retain staff; (c) the assumption that nurses essentially are interchangeable employees; and (d) the assumption that adding new nurses to fill vacant positions will solve the hospital nursing shortage. Before a discussion on the viability of these assumptions, it is important to turn to the nursing literature to examine the perspective with which nursing views the shortage problem.

Nursing Perspectives on Nurse Shortage

From the perspective of nursing, the definition of the term "shortage" is an inadequate number of nurses to care for patients at some professionally determined level of adequacy. This definition is quite different from that used in economics because it includes the concepts of need and want, which are excluded in the economic definition. The nursing perspective considers some of the same factors identified in the economic view such as wages and benefits, but, given the broad definition of shortage implicitly used in nursing discussions, it is not surprising that this perspective attributes shortage to a wide range of conditions reflecting job dissatisfaction. While different authors order factors somewhat differently, there is remarkable consistency in their lists, which may be grouped into three general categories: (a) salary and benefits, (b) control over basic working conditions (e.g., hours, days, shifts and units and adequate numbers and the correct mix of nursing and support personnel), and (c) professional issues (including control over nursing practice, adequate autonomy for patient care, respect from others, especially physicians and administrators, and opportunities for growth and promotion). A fourth factor found in some shortage discussions is change in hospital demand for nursing as a result of increasingly complex technology, increasing patient acuity, and changing patient demographics, especially age (Aiken, 1982; American Hospital Association [AHA], 1981, 1987; American Nurses Association [ANA], 1983; Fagin, 1980; Institute of Medicine, 1981; Jacox, 1982; Prescott, Dennis, Creania & Bowen, 1985).

In general most of the factors cited in the literature have to do with why nurses are dissatisfied with their particular jobs in hospitals. These factors are relevant to understanding shortages at the institutional level through the link between job dissatisfaction and turnover since nurses leave particular hospitals because they are dissatisfied. However, as long as they simply move around among employers, and do not change fields within nursing or leave the occupation altogether, job dissatisfaction and turnover do not explain nurse shortage at the aggregate level of analysis.

Interestingly, although the professional literature has focused primarily on the institutional level and has identified job dissatisfaction, the action strategies of individual hospitals seem mostly concerned with solutions drawn from the aggregate economic perspective—increasing the nurse supply via recruitment—and are only secondarily concerned with addressing the job dissatisfaction, or retention. While there are exceptions, and some efforts to improve working conditions and provide for advancement are seen in the form of flexible scheduling options, development of career ladders and the like, the reason these factors have not been more seriously addressed is economic (Sloan, 1975). To explain, it is necessary to understand the concept of marginal costs and how they influence salary and benefit decisions.

A hospital with empty nurse positions to fill has two choices. It can raise nursing salaries in the hope of attracting new nurses to the hospital or it can seek per diem assistance; hiring the needed nurses on a temporary basis. Often, to get the needed supplemental nurses, hospitals have chosen the second approach even though they may pay as much as twice the hourly rate paid to regular staff members. The reason this approach is chosen is it costs less for the hospital to hire some highly paid workers than it would to raise the wages of *all* of the regular staff members to the level required to recruit nurses to fill vacant positions on a permanent basis. Consider a hypothetical hospital with 200 nursing positions and 50 vacancies. If temporary services were used to fill the 50 vacancies, the cost for one eight-hour shift (with staff nurses being paid $10/hr plus 20% fringe benefits and agency nurses being paid $15/hr, no benefits and a 20% agency fee) would be $21,600. If instead the hospital raised the nursing wage to $11.50 and tried to recruit 50 new nurses, the per shift cost would be $22,080. Thus, given the conditions of this example, as

long as the hospital fills less than 30 percent of its total positions with the more expensive temporaries, the marginal labor costs will be less than if the wage rate of the permanent staff members were raised (Prescott, 1982). Hence the easiest and least costly staffing remedy may serve to increase the long-term problem by holding down nurses' wages. Unless the temporary services bring increased competition to the hospital nurse market, and unless the higher wages paid these nurses translate into higher wages for permanent employees, the agencies may contribute to the dynamic shortage rather than serve a role in its solution.

There are numerous other actions taken by hospitals in attempting to cope with the nurse shortage at the institutional level. Unfortunately many of them have been cosmetic and not aimed at serious, long-range solutions to the major job dissatisfactions. Clinical ladders are a popular example of what is often a cosmetic change. The clinical ladder is designed to encourage nurses to stay in clinical nursing by providing promotional opportunities to reward clinical experience and/or advanced education. Unfortunately, in many situations advancement up the rungs of the ladder often means that the nurse is held responsible for more work, which is not rewarded with meaningful salary increases. Today the differential between a beginning and an experienced nurse remains very slim, with staff nurses in practice 5 years or less averaging approximately $22,000 per year, and nurses with 6 to 10 years' experience averaging $25,000 and gaining little thereafter ("Nursing Pay," 1985).

Many of the other actions taken by hospitals to cope with the nurse shortage actually make the problem worse. Perhaps the best example of this is what has been termed the negative staffing cycle. This exists when by choice or necessity a hospital attempts to function as usual in the face of a shortage of nurses. In this situation the existing staff members work harder, longer and more often and are responsible for more; this leads to what has been dubbed "burnout," which in turn leads to turnover among the permanent staff members (Prescott, Dennis, Creasia & Bowen, 1985). This process advances in a steadily downward spiral until the hospital finds itself no longer able to attract new workers. Cutting support staff members, "floating" nurses to other areas of the hospital, and failing to close beds or otherwise reduce demand for nursing services are other examples of actions that may actually worsen the nursing shortage at an institutional level. In general, short-range strategies that increase demands on existing staff members, coupled with actions that hold down wages of the permanent staff members would seem to work against any long-term solution to shortages at the hospital level. Before discussing this point further, we might first examine the current nurse shortage and comparing it with that experienced in the late 1970s and early 1980s.

The Current Shortage Versus The Past

Supply

In comparing the supply of nurses in 1985 with that of 1980 and 1978, it is clear that the number of nurses has grown and that the nurse supply has grown faster than has the general population (Aiken, 1987) (see Table 1). The number of nurses employed increased 36 percent during this period. Also the labor force participation rate of nurses has increased to 72.7 percent in 1977 to 78.7 percent in 1984 (this not only is there more nurses, but more of them are working (AACN press).

TABLE 1. Number of Employed Nurses, 1985, 1980, 1978

Year	Total Employed Nurses	Nurses Per 100,000 Population	Registered Nurse FTE Per 100,000 Population
1985	1,531,200	641	533
1980	1,272,900	560	470
1978	1,123,200	506	425

SOURCE: American Nurses Association (in press) Facts on Nursing, *Kansas City, MO: The ANA.*

The majority of working nurses are employed by hospitals. Despite often-heard statements about how nurses are being drawn off into the ambulatory care sector, the percentage of nurses employed in hospitals has increased from 61.4 percent in 1977 to 68 percent in 1984 (Division of Nursing, 1986).

Also of concern when considering the nurse supply are those nurses employed outside of nursing, those unemployed but seeking positions in nursing and those unemployed and not looking for employment. The percentage of licensed nurses employed outside nursing is low and essentially the same as in 1977. Nurse unemployment rates remain low in comparison with average female unemployment and slightly lower when comparing 1977 with 1984 (see Table 2).

The characteristics of the inactive pool are important when evaluating the nurse supply. While there has been considerable attention given to refresher courses and other means to draw nurses into the labor market, Johnson (1980) pointed out that a substantial portion of the inactive pool consists of individuals not likely to seek hospital staff nurse positions. For example, in 1977, 30 percent of those not employed in nursing were 60 years of age or over; in 1984, 36.5 percent of these nurses were 60 years of age or over; today even fewer of the inactive pool are likely to return to the labor force (Division of Nursing, 1986).

The supply of nurses licensed and available for work is at an all time high. In 1982 Aiken concluded that the nursing shortage in the early 1980s was at historically low levels, as evidenced by the large numbers of nurses and low levels of hospital vacancies. The situation now indicates an even larger nurse supply. Thus the currently experienced shortfall in hospital nurses cannot be attributed to a fall in the number of nurses available to work. Nor can it be attributed to nurses leaving hospitals for other health care sectors or for other fields of employment.

The immediate future, however, suggests quite a different picture than that seen during the 1970s and early 1980s. It is clear that the number of nurses entering the labor market has begun to decline (Green, 1987). Enrollments have been decreasing since 1983-1984, and these declines (5.3% in 1983; 8.1% in 1984,

TABLE 2. Percentage of Registered Nurses Employed Outside of Nursing and Not Employed, 1977, 1980, 1984

Year	Not Seeking Nursing Position Employed Outside Nursing	Not Employed But Seeking Nursing Position	Not Employed Not Looking	Average Registered Nurse Unemployment Rate	Average Unemployment Rate Women 25-54 Years
1977	4.4	3.0	27.2	2.8	6.4
1984	4.6	1.9	14.6	2.0	6.3

SOURCE: *Division of Nursing (1986).* **The registered nurse population: Findings from the national sample survey of RN's, November 1984 (Accession No. HPR. 0906938). National Technical Information Service, U.S. Government, Springfield, VA 22161.**

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7.5% in 1985) have begun to influence the number of nurses graduating, which decreased 2.5 percent in 1985–1986. These decreases are expected to accelerate in the near future (Rosenfeld, 1985).

During the period of federal support for nursing education, nurse enrollments increased steadily. Now, with declines in the federal subsidies for nursing education, it is likely that nurse enrollments will be more sensitive to such market forces as salary, with enrollments declining in periods of small salary growth and accelerating in periods of relatively large salary increases. In 1980 and 1981, when the nurse shortage was perceived as being acute in hospitals, salaries increased substantially, as compared to the increases seen in the 1970s (Aiken, 1982, 1987). These increases were followed by increases in the 1982–1983 enrollments, which tapered off as the salary increases slowed in the 1983 to 1986 period.

The historical trend of a steadily increasing supply of nurses growing more rapidly than the population probably is over. Enrollment data suggest that the supply of new nurses is in a modestly declining trajectory and can be expected to continue for at least the next four or five years as the smaller classes work their way through the educational system and enter the labor market.

Demand

Interpreting available data about the demand for nurses is more difficult than evaluating the nurse supply because there is less reliability and validity of the data, and their meaning are less clear. Demand for hospital nursing services is generally measured in terms of vacant positions—a measure that is less than ideal. Vacancies may be artifacts of restricted market conditions rather than true indicators of excess demand relative to supply. Hospitals are not disinterested parties in the definition of nurse supply and demand because they benefit from policies that make sufficient numbers of nurses available at existing wage rates; and hospitals may express their desire or need for nurses rather than a "demand" in the economic sense by reporting vacant positions for which they have no available funds (as is the case when "frozen positions" are reported as vacancies). These factors influence the statement of nurse demand which may be an underestimate or overestimate; vacancy statistics must be interpreted cautiously.

Nurse vacancy rates peaked in the early 1960s when hospitals reported an average of more than 23 vacancies per 100 budgeted positions. In response, salaries rose rapidly (twice as fast as did those of teachers and female professionals or technical and kindred workers), and the supply of nurses increased as both labor force participation and nursing school enrollments increased (Aiken, 1982). During the 1970s wages fell behind comparable groups as well as the rate of inflation, and by the end of the decade hospitals again were reporting vacancy rates in the range of 13 percent. The cycle repeated itself, with salaries rising relative to other occupations between 1980 and 1982 and vacancy rates declining to approximately 8 percent. Beginning in 1982 and continuing in 1983, demand for nursing services was curtailed in part by the general economic downturn of that period and in part by what appears to have been anticipation by the hospitals of the financial impact of prospective reimbursement. From 1983 until 1986 salary increases were low (under 5%) ("DRG's Stymie Wage 1987), and vacancy rates remained low until 1986 when they increased to 13 percent—the same level reported a decade ago (AHA, 1987). The increased demand for nurses expressed by the current 13 percent vacancy rate may be in part the result of substitution of Registered Nurses for other lesser skilled personnel, a phenomenon that occurs when the wages of Registered Nurses are low relative to the wages of LPNs and Aides (Aiken, 1982). Hospitals may also be using Registered Nurses in a variety of roles (e.g., quality assurance, discharge planning, home care coordination). However, even the 30 percent increase in the nurse-supply since 1976, and even the fact that hospital occupancy rates remained below pre-prospective payment levels (69% in 1985 vs 77% in 1982), it is difficult to understand the increase in demand for nursing services.

Using vacancy rates as indicators of there being a nurse shortage is problematic also because of lack of consensus regarding the importance of a given level of vacancy. For example, in 1980—when more than 28 percent of hospitals had no vacant RN positions; 39 percent had 1 to 9 vacancies; 34 percent had between 10 and 19 openings and the remaining 15 percent had 20 or more vacant positions—the vacancy rates were interpreted by some as indicating a severe and widespread shortage (Mullner, Byrc & Whitehead, 1982). Similarly, the AHA (1987) currently reports that 59 percent of hospitals report that fewer than 10 percent of their positions are vacant, but the average vacancy rate of 13.6 percent is interpreted as a shortage. Given the size of most nursing service departments, the number of vacant positions in the majority of hospitals would not seem to constitute a serious nursing shortage, and in historical terms the hospital vacancy rates were the same in 1977–1978, when vacancy rates were at 13 percent.

Patient acuity and changing patterns of patient care are other factors associated with demand for resources. Clearly, patient acuity has increased, as has the age of the population and the technological sophistication of the treatment. However, factors having had a dampening effect on demand (e.g., a decline in the number of hospital beds, the transfer of much care to the ambulatory, home care sectors) can also be identified. Iglehart (1987) suggests that there has been a dramatic decline in demand (based on 46.7 million fewer inpatient days in 1986, as compared with 1980), declining hospital occupancy rates (75.9 in 1980 to 63.4 in 1986), and closure of 414 hospitals (accounting for a loss of 56,628 beds). Aiken (1987) asserted that changing case mix may provide a partial explanation for the increased demand for nurses. However, it is unlikely that case mix alone could account for the current expression of demand.

Given the current supply, demand and wage situation, what can be concluded about the current nurse shortage, as compared with that of 1980? In the aggregate national market, the available labor force is larger than that in 1980. While many institutions experienced difficulty in recruiting and/or retaining RNs, many others did not; it would appear that the perceived nursing shortage was limited to selected hospitals and was of the equilibrium type resulting from market constraints and to some degree from geographic maldistribution of nurses at the aggregate level. The current situation seems much the same as it did almost 10 years ago with one very critical difference: the declining nursing school enrollments. With a steady or increasing demand for nurses and a dwindling supply of new graduates, supply-demand imbalance characteristic of dynamic shortages can be forecasted into the foreseeable future.

Remedies

Previous efforts to deal with the nursing shortage at both the aggregate and the institutional levels have emphasized recruitment as opposed to retention. Also, solutions appropriate at one level of analysis are not necessarily effective at another level, and it is important to include these distinctions in considering solutions. Lastly, it seems that the two major types of shortage, dynamic and equilibrium, call for different approaches, this also should be part of a discussion of solutions.

At the aggregate market level, the key factors seem to be wages, working conditions and competition. Economic theory suggests that the remedy for a dynamic shortage is to allow a freely competitive market to bid up wages to the level that, rela-

five to other occupations, nursing becomes attractive to individuals making career choices. Additionally, as adolescents and their parents consider occupational options, nursing will have to look attractive in comparison to the psychic rewards now available in business, law, medicine and other fields previously relatively closed to women.

Factors with a potentially positive effect on the nurse supply are those that raise salaries through such methods as collective bargaining or implementation of salary scales based on comparable worth evaluation studies or that stimulate competition. Competition, stimulated by pressure from other employers as well as from large-scale purchasers of health care, is for more nurse-provided services as an alternative to using more costly providers. Interestingly, supplemental agencies as competing nurse employers seem to have had only a transient impact on the nurse market since their higher wages have had little effect on marginal labor costs associated with permanent employees and hospitals have discontinued their services with any softening in demand. At this time hospitals have increased their control over the nurse market, and until this changes it is unlikely that alternative employers will provide sufficient competition to bid up wages.

Large-scale purchases of health care may create a demand for nurses in their search for cost-effective health care. This increased demand is only a potential; historically nurses have not marketed their services or attached clear costs to them. Increased consumer demand for nursing services could increase nurses' economic value in hospitals, thereby having a positive impact on wages. However, for this to happen, nursing would have to become more visible and articulate in defining nursing services, their value to patient care and their costs.

Factors with a potentially negative effect on the nurse supply include the surplus of physicians and the continuing and intensifying concern for cost containment in hospitals. The surplus of physicians has been well documented and is predicted to have lasting effects well into the twenty-first century. The cost-containment environment within which the health care industry functions places hospitals at greater fiscal risk than it had previously. As these pressures intensify, so too will competition among hospitals as they attempt to position themselves favorably within the prospective payment system. The effect of these pressures on nurse wages will be negative, and, as previously shown, wage suppression is a major factor in the creation of manpower shortages.

On balance, the search for cost-effective health care should favor nursing from the point of view of employers, consumers and other payors. To realize this potential, however nursing will have to separate its services from those of others, price those services, demonstrate their value and market them. Success in these endeavors should translate into enticing new people into the occupation. While the labor force participation of the existing nurse supply is at historically high levels, the concern with increasing the supply of new recruits is critical to the examination of the dynamic shortage anticipated at the aggregate level.

At the institutional level, the concern with recruitment is different than at the aggregate level. For hospitals, recruitment means attracting people who are already in the occupation to work in a particular institution, and in the past the success of the recruitment approach has been to a large degree dependent on a continuing supply of new graduates. But the supply of new nurses is now on the decline, making reliance on recruitment alone a less successful strategy than in previous years. The incentives for focusing on retention rather than recruitment have not been great. Sloan (1975) has shown that replacement costs have been inexpensive relative to the marginal labor costs associated with retaining staff members. While, in economic terms, this may still be true, the case for retention should be viewed broadly to include organizational and administrative considerations for the skill-mix needed to care for patients and the stability and maturity needed in staff members to prevent a negative staffing cycle in a time of changing demands. This is increasingly important as care becomes technologically more complex and specialized and nurses cannot be assumed to be interchangeable.

Many of the factors that nurses associate with a nursing shortage have only partially to do with vacant positions. There are four kinds of shortage, only one of which was the result of difficulty in filling vacant positions (Prescott et al., 1985). The other three shortage situations were the result of policies of hospitals that staffed so "thinly" that there were inadequate numbers of nurses to meet the nurse-defined need even on units where all vacant positions were filled. *Transient* shortages were short-term problems resulting from unplanned changes in patient acuity, staff absences, "floating" nurses and use of inadequately skilled or experienced staff members in place of permanent ones. While these problems were difficult to forecast, they were frequent especially in areas using large numbers of supplemental staff members on units with relatively unstable patients. *Scheduling* shortages were regularly occurring events planned for weekends, holidays, and off shifts when staffing is often at skeleton crew levels. Scheduling shortages are made worse by the simultaneous closing of many hospital support services such as patient transportation, social services and housekeeping. *Position* shortages result from allocating too few, or the wrong mix of, positions to a unit to meet patient care needs. This kind of shortage is widespread, planned and predictable and, even when all existing positions are filled with the right kind of skilled and experienced people, there simply are not sufficient numbers of staff members. The problem of position shortage has been aggravated in recent years by the planned reduction in nursing aides, ward clerks and other nursing support personnel.

Each of these situations can occur alone or, as is frequently the case in practice, in combination with other types. The result, particularly if the situation is allowed to exist for a prolonged period, is overextension and burn out of existing staff members. Patient care also is known to suffer because the nurses are less diligent in monitoring patients, preventing errors and trouble-shooting. Continuity of care also suffers greatly under conditions of shortage.

Clearly, part of the institutional shortage relates to difficulty in filling vacant positions, which may impart be because of aggregate supply issues. However, as much or more of the problem can be traced directly to hospital staffing policies that are both changeable and under the direct control of hospital and nursing administrators. These problems will not be solved solely by reliance on recruitment of new nurses. Rather a careful look at the job dissatisfactions identified in the nursing literature would focus the attention of administrators on retention of existing staff, improvements in staff competence, tailoring of the staff mix, and otherwise the establishment of policies and procedures with an eye toward long-term rather than short-term effectiveness and efficiency. Serious attention to job dissatisfaction will not be inexpensive since hospitals will have to pay a greater proportion of their budgets for nursing services, but the long-term payoff is high for individual institutions, for patient care and for health care costs.

Holding down nursing wages in an effort to deal with cost containment pressures will make the long-term shortage problem worse. Since increased salary costs can no longer be passed along to payors, institutions will have to reallocate internally the increasing hospital budget. By almost any estimate, nursing services are a hospital's best bargain, representing some 20 per-

cent of hospital charges. It is time that hospitals recognize and reward rather than burn out the source of this bargain.

Making the hospital a pleasant place to work in the fullest sense, (i.e. improving basic working conditions, paying competitive wages and benefits, providing opportunities for growth, stimulation and advancement and positively valuing the contribution of nurses to patient care), creates what has been referred to as the magnet hospitals, or those places that have little difficulty in recruiting and retaining nursing staff (ANA, 1983). Serious attention to making hospitals better places to work should translate into creating psychic incentives to individuals who are considering nursing as an occupation. A focus on retention of existing staff members by redress of the sources of job dissatisfaction can also play an important role in the long-term recruitment of new nurses.

The problems associated with nurse staffing in hospitals are complex and long standing. These problems are best addressed by a combination of the economic and nursing perspectives with a view toward long-term effectiveness and efficiency of the health care system. Nurse leaders can and should play an important role in using both perspectives and integrating their views to encourage a balanced approach to recruitment and retention of nurses.

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Senator HEINZ. Patricia, thank you very much.

I must say that you've all painted—those of you who are from the nursing profession particularly—have painted quite a startling, to me shocking and alarming picture. Alarming for many reasons. One reason is that you, Marie, and you, Joann, have seen and testified to the practical consequences in everyday life of being short staffed where nurses are concerned. And although you have given us examples from your own specific experience, I suspect that where there are nursing shortages, and the national statistics show, that there are, the consequences are not at all dissimilar from what you have described. Those consequences are not only dangerous but can, be life-threatening and even fatal.

Patricia, what you have testified to is an overview of some of the roots and sources of the problem, which if not attended to, will create even worse problems as more nurses leave the profession. And certainly, it's true that there are many more options open to women of all ages today who are seeking professional opportunities, than there were 10 or even 8 years ago in 1980.

My question to the Department of Health and Human Services and to Dick Loughery is this: First, do you generally perceive the consequences of the nurse shortage to be significant and serious and to have the grounds of very adverse or potentially very adverse impact on patients as has just been testified to?

Mr. LOUGHERY. With no question.

Senator HEINZ. With no question. I commend you for being not only farsighted but clear-eyed, Dick.

Mr. LOUGHERY. I have two daughters and a daughter-in-law who are nurses. I've also had a cardiac catheterization and coronary artery bypass graft and a couple of other illnesses. So I've both provided the profession some recruits as well as using them.

Senator HEINZ. You have not only put fresh people in the trenches, you have been operated on in the trenches.

Mr. LOUGHERY. Right.

Senator HEINZ. Now, Patricia indicated that there is a difference between, this nursing shortage and the other kind of shortage, the one that existed previously. She made the distinction between a dynamic shortage and an equilibrium shortage, and I'm particularly trying to recall my Economics 10 and 20 to recollect the difference between those two. But as she described the equilibrium shortage, the main question there was the provision of adequate wages by a fairly tightly organized hospital community. She says that we're in a dynamic shortage today—although, Dick, I must tell you I'm not quite clear on what the definition of a dynamic shortage is—but would you generally agree that this is a different kind of shortage?

Mr. LOUGHERY. Yes. I won't argue the economic terms, because I had a heck of a time with 101. But I think what Ms. Prescott is saying is that what I would call task compression, and that is pushing more work off onto nurses, as my colleagues and former colleagues and hospital administrators have cut staff. They've cut the housekeeping staff and the other support services and have pushed those jobs onto nurses, who are at the same time confronted with the same things that these ladies have recited of more work with sicker patients, and at the same time having to be smarter with

the technology. All of these are horrendous portions pushing on fewer people.

Senator HEINZ. Now, explain a little bit more where these chores are being pushed from.

Mr. LOUGHERY. Well, as one gets near the caps of the DRG's, the diagnostic—the diagnostic related groups of Medicare patients, and as they inherit by virtue of good art and science more and more Medicare patients, because the elderly population is growing, the economics of keeping the institutionalized become more acute.

Senator HEINZ. I just want to be clear on something. We all understand the impact of a graying America and DRG's. We understand the DRG's compresses the amount of time the patient is going to be in a given health care setting, in this case a hospital, and that that patient is going to be in a relatively sicker mode partly because of age, partly because we're much more careful about the admissions, and we understand that that means that the nursing is going to be much more intense.

Mr. LOUGHERY. Right.

Senator HEINZ. Or demanding. That's one factor, and that has been well understood. The other comment you made that I want to be clear about is that certain tasks that had been performed by somebody else are now being performed by the RN.

Mr. LOUGHERY. Yes, sir.

Senator HEINZ. Who were the somebody elses?

Mr. LOUGHERY. Housekeeping, dietary, central service, all of the so-called support departments.

Senator HEINZ. And they are performed by the RN because hospital administrators are making those decisions, or is it justifiably happening?

Mr. LOUGHERY. No. It's not just happening. It's because they have to cut expense in order to stay within the DRG caps. You're familiar with that?

Senator HEINZ. Oh, yes.

Mr. LOUGHERY. So——

Senator HEINZ. Are you familiar with the term sicker and quicker?

Mr. LOUGHERY. Indeed. We both read the same green sheet, I think.

Senator HEINZ. I claim authorship of those.

Mr. LOUGHERY. That's great.

Senator HEINZ. I don't claim authorship of them individually, however.

Mr. LOUGHERY. But in an effort to stay within the economic limitations, support staff is being cut, and their responsibilities are being shoved off.

Senator HEINZ. Let me ask Marie and Joann. In your testimony you described how both of you were or saw other nurses perform a variety of functions. The ones you described seem to me—because I'm an untutored observer perhaps—not to be so much support functions as absolutely essential functions. There just weren't enough nurses in intensive care or critical care or doing IV therapy. But is what Mr. Loughery testified to, have you seen support tasks of the kind that he has indicated being put on you or your colleagues, Marie?

Ms. W. I have two examples. An institution recently—within the city of Philadelphia, three institutions have laid off support personnel in order to decrease their budget because of the money that they are not getting from the DRG system. What they do is cut housekeeping and dietary and stuff like that.

In one institution the nurses were asked to start sorting laundry, heavy laundry which would include pillows, towels and blankets, put that in one receptacle, and put the sheets and the light stuff in another. And that's because they had to lay off some housekeeping staff and some people that were doing the linen. In that institution the nurses refused to do it, because they all stuck together. But these are the kind of things they were being asked to do.

We're being asked to give out dietary trays. We are being asked to take orders for things. Where there used to be clerks and dietary people to do this, we are now doing that in addition to the care that we're supposed to be giving.

Senator HEINZ. Joann, what are you seeing?

Ms. JOANN B. I guess I can add a little to what Marie had to say. Nursing has always been—can I phrase this—we could do everybody's job, but nobody could do ours. So as the cutbacks have come in and the ancillary staff has been cut back, we just automatically have to pick these tasks up. Someone has to do them, and who better to do them than the nurse? You know, she can do it. Let her do it.

We run all of the errands, run to the labs, run to the blood bank. The big thing that I'm dealing with now is wiping up the floor, because there's not enough housekeeping people. So if there's vomit on the floor or some other product, we have to wipe up the floor. Then the housekeeper will mop the floor.

When we have an emergency with a patient and there are packages and containers all over the room, I mean, it just looks like a cyclone went through, we have to completely clean the entire room, and then the housekeeper will come in and mop the floor.

Senator HEINZ. Now, is that a significant change from, say, as little as 5 years ago?

Ms. JOANN B. Oh, definitely.

Senator HEINZ. Would you say that adds 10 percent or 20 percent more to your duties and time, or is it more or less than that?

Ms. JOANN B. Absolutely. And it takes an hour to clean up a room after a medical emergency for the nurse, approximately an hour.

Senator HEINZ. Patricia, do you have any insights on this issue to the extent to which nurses are now being required to perform tasks that were performed by lower level personnel before?

Ms. PRESCOTT. Yes. I think from an economic viewpoint, the substitution of registered nurses for other workers is characteristic of what you see in a market where wages are very depressed, and the registered nurse relatively is a bargain compared to the people she's replacing. She's a much more versatile employee, so you see a downward substitution going on in hospitals.

There is also some data that suggests the registered nurse time is so taken up with the support of other departments in the hospital that as little as 25 percent of the nurse's time is spent delivering direct nursing care to patients.

Senator HEINZ. We all know that the salaries of nurses are very compressed. What's the interim salary for a nurse in a typical market area compared to the total employment cost of a nurse compared to the total employment cost of some of the support people who are being laid off? Can you make a comparison there? Is it $22,000 versus $17,000? I have no idea.

Ms. PRESCOTT. I don't have the current LPN starting salary figures in my head, so I can't give it to you, but it is much narrower than it has been in other eras.

Senator HEINZ. A comment on that?

Mr. LOUGHERY. Yes, sir. I think it's kind of a national figure. It's comparing youngsters starting in four different careers, advertising, business office/secretarial type, computer programmers and engineers, on a 6-year span, nurses come out terrible. They start at about 23, and they will finish at about 25 or 26. Now, that doesn't account for San Francisco where they start 38½ and end up at 48. But it so happens that the garbage collectors still make $2.25 an hour more, so all things are relative.

But the engineers do better, and the computer programmers do better. Office and clerical does better. And that's one of the things that Ms. Prescott was referring to. These are things that are attracting young people away from nursing. The opportunities are far better, getting away from all of the frustrations these folks are talking about.

Senator HEINZ. Now, just to interrupt at that point. You said that there are several other reasons which exacerbate the two prime factors which you mentioned in your testimony. Are you citing some of the Commission's findings?

Mr. LOUGHERY. Well, that happens to be one of them, yes, sir.

Senator HEINZ. What are the others? Could you give us a picture?

Mr. LOUGHERY. I think the chronic shortage of registered nurses, and this, I know, is one of your favorite subjects, in nursing homes is being further aggravated, exacerbated, worsened by the overall nursing shortage. Home health care, that use to be kind of a kind old soul who came in and helped the wife have the baby. Now these people are working evenings, nights, weekends, are high tech, render all medications. They have very sophisticated folks now.

AIDS epidemic coming along requiring more and more nurses. And our own hospital, the National Institute of Health and Clinical Center can't even open a unit. PHS is short 400 nurses between Public Health Services and NIH. The Army is short 30,000 Reserves, Air Force and Navy are also short. Minorities and men are badly underrepresented, but it's going to stay that way until there's something for them that they can support a family on.

One that hasn't been mentioned; that is the supply of nurses that are prepared for leadership positions, clinical practice and administration, education and research, don't meet current requirements, and there are not enough of them in graduate programs or sufficiently experienced to satisfy the needs for some really gung-ho leadership.

I think I've covered them all. One, which I will condemn my own types, is that the changes in the employment patterns of women require a more aggressive response by employers of nurses.

Senator HEINZ. Why do you suppose hospitals don't see what is, at least as you paint it, a very clear picture? At least to this observer a hospital is a place to work which either burns you out or diminishes your professional satisfaction, underpays you, or all three at a time. This is all happening when there are better opportunities for women generally and professional women in particular?

Is that an accurate picture, and if it is, why doesn't the leadership of the hospital understand the problem and attempt to do something about it? Are they simply hamstrung because of lack of money, or is it that hospital administrators are more concerned with the physician issues than the nurse issues? What is the reason? Anybody want to talk to that?

Mr. LOUGHERY. Somebody has said that 11 percent is too much of the GNP to spend on health. The problem starts from there and goes down.

Ms. PRESCOTT. I wouldn't agree with that, because hospitals are making profits, and physician income is doing quite well. The discrepancy between nurse income at approximately $20,000 and average physician income at somewhere between $100,000 and $150,000 is widening, that gap is widening. I think what we need is a redistribution of the pie. Let me just——

Senator HEINZ. Were you about to say something you were going to regret?

Ms. PRESCOTT. No, I forgot the last part of your question.

Senator HEINZ. Well, the question was, is it just a question of money, or hospital administrators, are they constrained in some way to addressing nursing? Don't they want to? Are they ignorant to the problems? You know, I'm not trying to be mean to hospitals administrators or hospital boards, but they have the responsibility for which they have many legal liabilities should they fail to meet those responsibilities. To the extent that people are falling down and breaking their hips and dislocating their shoulders or having their heart stop and die or suffering damage to their heart muscles, to name three specific instances that are testified to here today, most hospitals, I think, try to run themselves well. The people try to be conscientious. If I was a board member or a hospital administrator and I knew about those problems, I would be very concerned. So I assume that there either are terrible constraints, or there's a lack of knowledge.

One, constraint certainly is money. We understand that. Are there others?

Ms. PRESCOTT. I don't think hospitals have had to worry about the long-term effect of this in terms of nursing staff, because they have historically had a large continuing supply of new recruits each year entering the labor force at the June graduations to replace those people that have chosen to leave.

In some institutions frequently referred to in the profession as magnet hospitals, administrators have learned that it's in their own enlightened self-interest to have a strong and valued nursing staff. In those institutions there is no shortage. In fact, in some of them there are waiting lists of nurses wanting to work there. It is possible to provide effective nursing service within the reality of the current cost containment environment, but it takes a fundamental reordering of priorities and the valuing on the service that

has not been there. Hospitals have not needed to do that, and economically it has been to their advantage to replace rather than retain. That is going to change now as the supply dwindles.

Senator HEINZ. And it will also change as skill levels based on experience become more important.

I really have two more questions. One is, what are the characteristics of these institutions, and if you care to name a few that do a good job in retaining, attracting nurses? Are they teaching hospitals? Are they rural hospitals? Are there any common denominators, and if so, what are they, or are they just isolated instances of brilliant problem solving?

Ms. PRESCOTT. Well, I think there are some common denominators, and one of the most fundamental ones is in the attitudinal set that puts a premium on the value of nursing. Similar to what Marie said, when you walk into an institution and have the CEO tell you that a hospital is a place to deliver nursing service, it's the premier service of the institution, and everything is organized to facilitate that delivery——

Senator HEINZ. Is that opposed to an operating theory?

Ms. PRESCOTT. That is opposed to nursing as a support service for everybody else.

Senator HEINZ. Oh.

Ms. PRESCOTT. You see a whole different organizational structure where the attitude is, how can we facilitate your delivering nursing services?

Senator HEINZ. Why are some hospitals that way and most not? Is it the attitude of the CEO? Is it the mission conceived for the hospital by the board, or is it some—is it luck? I mean, what is it? Anybody want to take a crack at that?

Ms. W. I think it has a lot to do with management structure. What's going on in the business nationwide with changing attitudes on how to deal with workers and getting workers involved in decision-making processes is the same problem in hospitals, which I think it dies harder in hospitals than it does in business.

One of my recommendations was managerial style. Not the old Army type style.

Senator HEINZ. Actually, your second and third recommendations I thought, made the same point which is change the way you think about nurses and realize that they are the heart of the institution.

Ms. W. In the packet that I gave your staff yesterday, there's three articles. One talks about the magnet hospitals and the characteristics of them. One just shows you a real big scenario of what it's like to be a nurse. And the third one talks about four hospitals that are doing something new and innovative with the shared governance and participation between management and why they are succeeding at it.

Senator HEINZ. Are they doing better at keeping their nurses?

Ms. W. They are doing better—the really good thing, I think New England Clinic is doing it—they are saving the hospital's money. The patients are getting out faster. They are getting out better, because nursing is controlling how their services are provided, and that is the end result. We want the patients to get better. We want them to get out faster, and they are saving the hospital money.

Senator HEINZ. I hope the audience is filled with hospital administrators and board members who hear all of this. Yes?

Mr. LOUGHERY. One other point, and that's the recognition of the chief nurse, going by any number of titles, as being in the same peer level of the management hierarchy, particularly the financial guy, the operations person, and most importantly, the chief of the medical staff. That's one of the reasons for New England's success, the chief, the administrator is a physician. He buys the top ranking nurse, and thus the peer level is there. That gives all of the other nurses one shot of adrenalin, I tell you.

Ms. W. Many hospitals don't have that. The chief of the nursing service is way down the line.

Senator HEINZ. There's a lesson from the military here, which is that, the officers can issue all of the orders that they want, but unless there's a chief master sergeant who is really good, nothing really works. And the nurses are the chief master sergeants of the health care profession, and without them, nothing really works.

Let me ask this. In terms of options for Federal policies, Patricia, you indicated that you thought that—and made it quite clear in saying that this is both a public and a private responsibility. For obvious reasons it has to be. You made very specific recommendations about how Medicare should consider restructuring its indirect and medical payment component to take specifically into account the provision of nursing services in a way that it would, I suppose, shock the controllers and accountants at every hospital. We don't have that information. I gather that is a problem, hospital accounting systems would probably take some time to be able to be responsive to that kind of change; is that right?

Ms. PRESCOTT. Very few hospitals currently bill for nursing services on a regular basis. The ability to do it is there. There needs to be some motivation to encourage more hospitals to do that and do it in a uniform way so that the data can be collected to form a national data base, which we do not have.

Senator HEINZ. Let me ask Mr. Loughery, what do you think the chief options that we should be thinking about are as we look forward to your May report? Can you genuinely approach that topic without letting the cats out of the bag? Of course though, that's what I want you to do.

Mr. LOUGHERY. The options that are going to come will have to have a lot of refinement, the thing you were just discussing. Now, HCFA is beginning to work on that, and I think it's very important, at least the four of us and some of the other panels will know of projects that have gone on to try to determine what is the nursing care portion of any disease. Now, when that can be recognized and paid for, just like paying physicians for procedures and treatments, that will go a heck of a long way, because we all feel that it will push enough money that is for nurses. You sure as heck can't give it to the dishwashers.

Senator HEINZ. Is what we've heard today, an argument for redoubling our efforts to develop a severity of illness index for DRG's?

Mr. LOUGHERY. No question, yes, sir.

Senator HEINZ. How are we doing on that?

Mr LOUGHERY. Slowly. But it is extremely complicated.

Senator HEINZ. I understand that. I saw briefly over the weekend a little reprieve on the Manhattan project where they sent Dr. Oppenheimer out to New Mexico in 1943, and they just kept sending more Nobel Prize winners out there until they got the job done, which was a mushroom cloud over the desert about 18 months or so later.

Now, it would seem to me that if we can—solve that kind of absolutely earthshaking issue in 18 months, by applying enough brain power we ought to be able to get at the severity of illness index in something shorter than the 2 or 3 years since I held the first hearing on that subject. The idea had been kicked around Johns Hopkins for a few years before that. I can't believe that if we said we really have to have this that we couldn't get it in a year.

Mr. LOUGHERY. I would hope that it would not be a year, Senator. Maybe a year to develop it and publish the thing and gather experience with it, but for goodness sakes, let's don't do it like we did the prospective payment program before we knew what the experience might result in. We need to have it without question, but when we do get a model, let's try it for a while.

Senator HEINZ. Well, I'm not opposed to that.

Mr. LOUGHERY. We can't do both in a year, is what I'm saying.

Senator HEINZ. No, but where we are, we are not even in a position to try anything right now, and it's 3 years later.

Mr. LOUGHERY. Although there is, I believe, a lady who has just joined the University of Pennsylvania staff who has had some experience.

Senator HEINZ. Well, I'm certain——

Mr. LOUGHERY. Am I correct?

Senator HEINZ. But the point is, we have not got a single Federal demonstration project on the severity of illness.

Mr. LOUGHERY. I do not know the answer, whether we have or have not.

Senator HEINZ. I hope that will be a very important part of your recommendations. It's not the only answer, but it seems to me to be an essential component of the answer. Otherwise, we'll just be arguing about reallocating. You know, there will not be the proper base on which to allocate money for nursing or anything else.

Well, are there any concluding comments any of you would like to make? Patricia?

Ms. PRESCOTT. One thing I would lke to say is that there has been a study commissioned by HHS and conducted by Applied Management Sciences to identify the direct nursing and Medicare passthrough dollars. That study has not been released and it would be very helpful to have it released.

Senator HEINZ. Let me ask one last question. Would it be useful to target training funds and provide loan forgiveness for RN's who will agree to practice in the most difficult and least desirable specialty setting, or would that be only a continuing of the same old methods?

Mr. LOUGHERY. We've done it before. We did it, oh, about 10 or 12 years ago.

Senator HEINZ. Is it the relevant thing to do today?

Mr. LOUGHERY. You do it with doctors. National Health Service Corps works that way.

Senator HEINZ. So that's a yes?

Mr. LOUGHERY. Yes, sir, just as an example we have done it in the past with nurses and we continue to do it except in an increasing number with physicians. It's an indenture type thing, but it's a pretty cheap way for a person to get a medical education.

Senator HEINZ. Any comments on that question, Marie or Patricia or Joann?

Ms. JOANN B. My gut feeling is that is like a band-aid type of solution, not fixing the workplace which is where the problem is. Now, I think if you fix the workplace enough, the nurses are going to stay and they are going to be drawn to that. It's definitely a very good option for somebody to go into if the salary is there, if the personal and professional satisfaction is there you're going to draw the nurses in.

Senator HEINZ. Very well. May I thank all four of you. You've been an absolutely spectacular panel of witnesses, and I appreciate your laying out, I think extremely clearly, what problems we face, what the consequences of those problems unresolved are and how they will get worse if we don't do something about it. Thank you all, very much.

Mr. LOUGHERY. Thank you.

Senator HEINZ. I'd like to call our next panel of witnesses, Mr. Perry Pepper, Dr. Mary Naylor, Dr. Paul Willging, and Dr. George McNeal representing, respectively, the Hospital Association of Pennsylvania, the Pennsylvania Nurses Association, the American Health Care Association, which are principally the proprietary nursing homes, and the Veterans' Administration Medical Center. And I'd like to say a special word about Mary Naylor who we've been privileged to have working with the Aging Committee staff during an all-too-brief 6-month fellowship, special assignment where we were able to benefit from her knowledge and views back in what, 1986?

Ms. NAYLOR. I worked with the committee in 1985 and 1986 during the hearings on the "Impact of PPS on Quality of Care" hearings. I thoroughly enjoyed this experience. I'm pleased to have the opportunity to testify before this committee today.

Senator HEINZ. Let me ask Mr. Pepper representing the Health Care Association of Pennsylvania to please proceed.

STATEMENT OF PERRY PEPPER, PRESIDENT, CHESTER COUNTY HOSPITAL, CHAIRMAN OF THE BOARD, HOSPITAL ASSOCIATION OF PENNSYLVANIA, AND DELEGATE, AMERICAN HOSPITAL ASSOCIATION

Mr. PEPPER. Thank you, Senator; my name is Perry Pepper. I should correct the record. I am not a physician. My family has a series of physicians and senators, but I'm not a physician. I'm purely a hospital administrator.

I am president of the Chester County Hospital in West Chester, PA. I'm chairman of the board of the Hospital Association of Pennsylvania and a delegate to the American Hospital Association. It is in these capacities that I wish to thank you and your committee for the opportunity to appear here today to offer our industry's perspective on the very important issues surrounding the current

nursing shortage and its effect on the hospital community. I have presented to your staff two separate statements, one prepared by our State Hospital Association and one prepared by the American Hospital Association.

Senator HEINZ. Without objection, both of those statements will be part of the record.

Mr. PEPPER. Thank you, sir.

Each are worthy of being read in their entirety, and I hope that you and your staff both have the opportunity to review them, because they represent many months of important collecting data and analyzing it. Together I believe they will give you a better understanding of the various factors which make up the supply and demand equation which ultimately leads to the patient's bedside.

Because I recognize your time here today is somewhat limited, I submit these documents for your review, but I would also like to give you a distillation of these statements highlighting those areas which are our greatest concern.

Unlike previous shortages, we are convinced that this one is not likely to ease in the foreseeable future. Major changes in the health care environment as well as rapid changes in our country have drastically increased the demand for nurses. While at the same time reduced their supply.

We have well documented the components of this problem both in your State and across the country. It is not a shortage due to uneven distribution, nor is it because nurses are leaving the field of nursing. It is in its most elemental form a problem related directly to the prospective payment system and the seriousness of unforeseen consequences which occurred when Congress created incentives for hospitals to condense the care of hospitalized patients to shorter and more intense episodes.

Shorter lengths of stay and sicker patients has meant an increased demand for nurses evidenced by staffing ratios which have gone from 50 nurses per 100 patients in the 1970's to 91 nurses per 100 patients in 1986. This increased demand not only comes at a time when there are fewer young women available to enter the profession—and I say "women" because it is still a profession that attracts mostly women—but also it comes at a time when the professional choices available to female students are much greater than they've ever been before. Consequently, enrollments at all levels of nursing education have sharply declined. It is clear we need to make this profession more an attractive choice than it is today.

Hospitals in your State and across the country have been innovative in developing nurse recruitment and retention programs. Most are exploring new ways to enrich the nursing experience, provide upward mobility within the profession, and attract students to a nursing career. Unfortunately, since we now know that over 80 percent of Registered nurses are actively employed, short-term solutions will be limited as there is already a very high labor force participation.

In the end, there is only one solution which would eventually reverse this trend, nurses will have to be paid, not only for competitive starting salaries but also be able to seek continued salary

growth over their career before we can expect to attract greater numbers to the profession.

It is somewhat ironic that the very payment system which has led to the increased demand for nurses will also prevent hospitals from paying the nurses more competitive salaries. Hospitals today are being inadequately paid by Medicare for the care delivered for the older population. The prospective payment system has not kept pace with the cost of goods and services which our hospitals must purchase. Most analysts today, including the Prospective Payment Assessment Commission, project hospitals fiscal year 1988 PPS payments to be below costs for negative margins in the aggregate.

Just as ironic is the fact that the hospital Medicare trust fund is more than adequately funded to provide additional moneys to help solve this problem. Congress could make a major contribution to the resolution of the nursing shortage by insuring that hospitals receive accurate Medicare and Medicaid payments and that nursing students at all levels of nursing education receive better Federal support.

Finally, I am of the opinion that in the long run we must prepare our Registered nurses to supervise care given by those who have fewer years of education. There are many things that alternative nursing personnel could do with the supervision if we were to analyze the scope of nursing practice. In other words, nurses are also part of the solution. The primary nursing care model should not mean that a patient's total care be given by a single one but rather that his care be managed by someone with primary responsibility.

This change in philosophy will allow greater upward mobility for nurses as they acquire new management responsibilities. It would permit greater participation in nursing care by non-RN's, and it would allow hospitals to pay a relatively smaller number of RN's in a more competitive salary.

In Pennsylvania educators and providers are beginning to sit down together to explore such solutions with the help of their hospital associations.

Senator, I think that you should be proud of the leadership role the Pennsylvania hospitals have taken in understanding this problem and being innovative in seeking solutions. I might also add in Pennsylvania, unlike many other States, we are developing a severity program under the Medis Group [sic] system, and you shortly will have a good deal of data upon which you could base the national solutions.

But we cannot solve the shortage without adequate resources. Pennsylvania hospitals as well as all of our Nation's hospitals join me in thanking you for this opportunity to share our concerns, and we hope that your committee and staff will have the time to read our more detailed statements.

Of course I'll be pleased, time permitting, to try and answer any questions you may have.

[The prepared statement of Mr. Pepper follows:]

ASSOCIATION
PENNSYLVANIA

Statement of

THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

before the

SENATE SPECIAL COMMITTEE ON AGING

NURSE SHORTAGE FIELD HEARINGS

Presented by

H.L. Perry Pepper

Chairman of the Board

Philadelphia, Pennsylvania

April 6, 1988

Senator Heinz, my name is Perry Pepper and I am president of Chester County Hospital in West Chester, Pennsylvania, and Chairman of the Board of The Hospital Association of Pennsylvania. The Association represents some 260 general acute care and specialty hospitals in the Commonwealth.

Pennsylvania's hospitals appreciate this opportunity to appear before you and the committee to offer our perspective on the nursing shortage in the Commonwealth of Pennsylvania and steps that Pennsylvania's hospitals are taking to address the shortage.

Pennsylvania is particularly important in this study because we are the third largest educator of nurses in the nation. There currently are 31 baccalaureate programs, 22 associate degree programs (with approval granted for two more to open), 35 diploma school programs, and 50 practical nursing programs.

Unfortunately, despite our leadership role in nursing education, we are unable to keep pace with the demand. The Pennsylvania Department of Labor and Industry projects that for the decade of the 1980s, the Commonwealth will have an annual demand for 6,051 nurses. In 1987, however, the number of registered nurses endorsed into Pennsylvania was 2,112 while the number endorsed out of Pennsylvania was 5,090. Pennsylvania nursing schools each year graduate fewer nurses than the number needed for Pennsylvania alone. Then, many of these nurses choose to practice in other states, reducing the number available to take positions in Pennsylvania still more. This out-migration is hurting Pennsylvania considerably as it tries to staff its health care facilities sufficiently.

National studies have indicated three main reasons for the nation's nurse shortage: (1) fewer applicants to nursing schools; (2) staff turnover in hospitals; and (3) an increased demand for registered nurses inside and outside of hospitals.

Much of our understanding of the situation in Pennsylvania comes from a statewide nursing study completed in 1987 by the Hospital Research Foundation, an affiliate of The Hospital Association of Pennsylvania.

The study was designed to collect data in three areas--nursing education, nurse supply and demand characteristics, and attitudes of licensed nurses toward the nursing profession.

I'll give you some of the highlights of this study and then comment on steps being taken to address its findings and their implications for the short- and long-term.

The survey indicated that full-time student enrollments have declined for the past two academic years for all four levels of nursing education--baccalaureate, diploma, associate degree, and practical nursing program. Declines also were recorded for part-time students in diploma, associate degree, and practical nursing programs, while baccalaureate programs experienced increasing enrollments for part-time students.

These findings indicate a problem that will continue for the foreseeable future.

The statewide nursing study found vacant positions for registered nurses and practical nurses across three employer categories that together employ the vast majority of nurses: acute care and specialty hospitals, long-term care facilities, and home health agencies. A 6.4 percent vacancy rate was demonstrated for registered nurses and a 2 percent rate for practical nurses.

In each of the three employer categories, vacancy rates for registered nurses were demonstrated; 6.8 percent for acute care and specialty hospitals, 3.8 percent for long-term care facilities, and 3.5 percent for home health agencies. Vacancies for practical nurses were experienced only by acute care and specialty hospitals.

The greatest need was demonstrated on medical-surgical services within acute care and specialty hospitals, which experienced an 18.9 percent vacancy rate for registered nurses. The next greatest need is in critical care units of acute care and specialty hospitals.

A survey conducted two months ago by the Hospital Council of Western Pennsylvania indicated a registered nurse shortage of 5.4 percent in 53 hospitals which responded to the survey. The vacancy rate was 9.8 percent within the city of Pittsburgh, just over two percent in the surrounding counties, two percent in the Johnstown-Altoona area, and less than five percent in the northwest corner of the state.

Some 68 percent of registered nurses employed in Pennsylvania are in health care institutions. The demand for nurses is increasing partly as a result of changing practice patterns in hospitals brought about by the prospective payment system for Medicare and its influence over treatment of all patients.

As a result of financial pressures to increase efficiency, only patients who require the level of skilled care provided in hospitals remain hospitalized. Thus, today's hospitalized patient is much more severely ill than in the past and sicker patients require more intensive nursing care. Virtually the same amount of nursing care must be compressed into a shorter period of hospitalization.

The increasing demand for outpatient care also is feeding the demand for registered nurses and taking nurses away from inpatient service sites.

Having defined and analyzed the extent of the problem in the Commonwealth, Pennsylvania's hospitals are undertaking measures to reduce the shortage.

For example, hospitals which are associated with the Delaware Valley Hospital Council have started three programs to bolster nurse recruitment: a registered nurse job bank, a student nurse tuition loan program, and a high school recruitment campaign.

The job bank is to provide a centralized information source of all registered nurse vacancies at participating hospitals. The job bank is to be advertised regularly in the major local newspaper and in nursing journals. Forty-three hospitals contributed more than $200,000 to fund the program. The money will be used primarily for advertising.

The tuition loan-forgiveness program will be for students who attend any existing entry level nursing education program in southeastern Pennsylvania. Students may either repay their loan or earn loan-forgiveness credits by working at a participating hospital following graduation. The program is designed to provide assistance to financially needy students who are completing the last two years of an educational program preparing them for registered nurse licensure eligibility.

The high school recruitment campaign is to be carried out by hospitals "adopting" an area high school and providing up-to-date information on nursing career opportunities to students, parents, guidance counselors, and teachers. Nursing schools will provide data on the number of applicants they receive so the effectiveness of the program can be tracked. There are plans to expand the effort to junior high schools.

In addition to the regional efforts by the Delaware Valley Hospital Council, many individual hospitals are undertaking innovative programs to recruit and retain nurses.

Western Pennsylvania Hospital in Pittsburgh offers nurses 40 hours' pay for 24 hours of weekend work. Nurses can either work 40 hours Monday through Friday and have every weekend off or they can work 12-hour shifts on Saturdays and Sundays and receive the same pay. Ironically, solutions such as this one are creating new problems. Nurses teaching in nursing schools are seeing that they can earn more money and spend more time with their families by leaving their teaching and working weekends at a hospital. This is having an adverse impact on the ability of nursing schools to retain good instructors.

Pittsburgh's Shadyside Hospital has developed a "clinical ladder" to address the problem of wage compression, maximum salaries after years of service that often are as little as 30 to 50 percent over a starting salary.

Shadyside took its basic job description and divided it into four different descriptions, each clinically focused. There are four levels, ranging from novice to expert, and salary increases are given for each of the levels.

At Mercy Hospital of Pittsburgh, nurses are given responsibility through a "primary nursing" approach. Each patient is assigned a primary nurse who acts as the coordinator of that patient's care from admission to discharge. The primary nurse works closely with the patient, family, and physician to tailor the treatment plan to the patient's needs and wishes. The nurse also makes sure those on other shifts know of decisions made concerning the patient.

Mercy also is developing a clinical ladder for payment purposes and uses a variety of employee recognition techniques, including cash bonuses.

Abington Memorial Hospital uses a variety of techniques to keep more nurses on staff than needed. These include nursing recognition programs, awards, flex-time options, and use of a relief staff that works every other weekend. Another factor cited by the hospital is the atmosphere and commitment to nursing excellence from the hospital board and medical staff.

Finally, at my own hospital, our board has taken a particular interest in our school of nursing and has assigned a committee to guide the nursing education program. This involvement has led to enhanced student recruitment. We also hire licensed practical nurses and help them with the transition to registered nursing. Our LPNs have three grades, each with its own salary level in recognition of increased responsibilities. Once at the highest level, LPNs have an opportunity to take a test and, if they score 80 percent or higher, become eligible for our diploma school. If graduates of our school remain on staff for at least two years after graduating, we reimburse them for their last year of schooling.

Another cooperative effort is a nurse training demonstration project being put together by the National Union of Hospital and Health Care Employees and a group of cooperating hospital executives and nursing home operators. The intention of the project is to: increase available nurse training positions, focus training efforts on people who will stay within the local health care industry, increase the retention rate within nursing education, stabilize the nursing home work force by creating a clear career ladder, retrain and reemploy some of the thousands of health care workers laid off in the past three years, increase the opportunity for current health care workers to become nurses, and make nursing a more attractive occupation.

This effort will particularly focus on current health care workers and on minority applicants.

At the state level, The Hospital Association of Pennsylvania has conducted a successful Be A Nurse campaign for several years. This effort provides information and recruitment materials to hospitals to use and also directly to school guidance counselors.

The most exciting statewide response to the problem is the nursing educational alliance proposal which came out of the Hospital Research Foundation's statewide nursing study.

It has been proposed that a nursing educational alliance be created through which the primary players having an impact on the supply of and demand for nurses would be operationally linked, specifically, an alliance of educators and employers.

The operational characteristics foreseen for the alliance include: (1) a vertically integrated educational network accounting for the various levels of nursing education; (2) employer participation through faculty supply and support, student clinical experience opportunities, curriculum development, employment opportunities, financial support, faculty research opportunities, etc.; (3) centralized administration; and (4) decentralized educational sites.

The Hospital Association of Pennsylvania has named four work groups to address aspects of the statewide nursing study--education/administration; recruitment/retention strategies; scope of nursing practice interpretation/evaluation; and collaborative support for nursing education.

While these solutions will take longer to implement and to produce results, we believe they are likewise much more likely to be permanent solutions rather than temporary palliatives.

Because there have been many suggestions regarding using increased nursing salaries as a solution, I want to share with the committee an

analysis which has been done of a proposal to have a minimum salary for a registered nurse of $30,000 and a maximum salary of $50,000 by 1990. This proposal has become known as the 30-50-90 proposal.

The 30-50-90 proposal was analyzed by the Hospital Research Foundation using statewide nursing study data that indicates that 90 percent of the full-time equivalent registered nurses employed in Pennsylvania hospitals earn an annual income of less than $30,000. The remaining 10 percent earn more than $30,000 but less than $50,000.

It is estimated that the increase in the payroll expense for registered nurses as a result of paying them the difference between their current salary and the wage deemed appropriate in this proposal would be $486 million above and beyond current labor expenditures.

If the number of registered nurses employed in hospitals in Pennsylvania increases five percent (the level of last year's increase) and the current salary distribution is applied to the 30-50-90 proposal, the estimated new dollars required increases to $511 million. If the number of registered nurses decreases by five percent and the salary distribution remains the same, the estimated additional funds required would be $462 million.

In summary, the salary increase associated with the 30-50-90 proposal is approximately 11 percent of total hospital expenses. Historically, the increase in total operating expenses has been eight to nine percent; the 30-50-90 proposal would add another 11 percent to the rate of increase in hospital expenses, if everything else remained constant.

While Pennsylvania hospitals support the use of financial incentives as a means of attracting and retaining nurses, there simply are not funds available to do anything like the 30-50-90 proposal.

It should be noted, also, that the 30-50-90 would have a ripple effect through the hospital if implemented. It would be impossible to make such a drastic increase in nurses' salaries without also increasing salaries of other classes of employees comparably. The financial burden on hospitals would be immense, particularly in light of restricted Medicare payments. As you are aware, Pennsylvania is now third in the nation in terms of the elderly population and thus adequacy of Medicare payment is an extremely important issue for Pennsylvania's hospitals. With our costs, including the cost of labor, rising at a significantly higher rate than increases in payments, hospitals are severely restricted in their opportunity to respond to issues such as the crisis in nursing. The question is not whether we want to respond, but rather whether we have the necessary

income to enable us to respond. And the answer is that today we do not have adequate reimbursement to allow us to do everything that should be done.

There is another aspect of the financial problem which is particularly affecting hospitals in the Delaware Valley. In the Delaware Valley, there are private agencies in business to supply registered nurses to hospitals and these agencies have no financial restrictions on them similar to the financial restrictions facing hospitals. The result is that many nurses resign hospital positions to work for the agencies since they can offer them higher salaries than the hospitals can. Agencies then force hospitals into bidding wars for nurses. I cannot propose a solution at this time, but I can tell you that many hospitals in this area are concerned about what seems like unfair and inequitable competition.

Through the statewide nursing study, the four work groups which came out of it, and the proposal for a nursing educational alliance, as well as initiatives being taken by individual hospitals and hospitals working cooperatively together, Pennsylvania's hospitals are taking a sound approach to the nursing shortage problem by carefully defining the issues and then seeking acceptable solutions for both the short- and long-term. Our ability to carry out these solutions will depend in large measure on the development of a Medicare payment program which adequately reimburses hospitals for their costs and allows them to plan for the future.

On behalf of Pennsylvania's hospitals, I appreciate this opportunity to address you today and I will be pleased to answer any questions you may have.

American Hospital Association

AHA

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
Cable Address: Amerhosp

STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SPECIAL COMMITTEE ON AGING
OF THE
U.S. SENATE

Philadelphia, Pennsylvania
April 6, 1988

The American Hospital Association, on behalf of its more than 5,100 institutional and 45,000 personal members, welcomes this opportunity to present its views on the current nursing shortage. Few issues are more vital to the hospital community.

Hospitals are employing more nurses than ever -- 25 percent more than they did before implementation of the prospective pricing system -- and patients are benefiting from a higher nurse-to-patient ratio. Yet, hospitals continue to seek more highly skilled nurses than are currently available. This has happened because hospitals and the nurses working within them are treating sicker patients and affording a wider range of services than they were five years ago. The current nurse shortage is only likely to worsen because fewer people are going into nursing than before. In addition, with less federal support for nursing students and schools, fewer nurses can acquire the advanced training they need to fulfill the complex demands of today's hospital environment.

Hospitals and their medical staffs are under pressure from all payers, including Medicare, to cut back on inpatient hospital admissions, and to use resources and provide services more efficiently. The unusually high demand for nurses may be a byproduct of this urge to economize. Fewer admissions and shorter lengths of hospital stay mean that the average patient in the hospital is sicker now than in the past, and requires more, and more highly trained, nurses to care for them. In addition, with shorter recuperative periods during which to prepare the patient for return to the community, hospitals have devoted more nursing resources to patient care planning, discharge preparation, and discharge placement.

If hospitals are to manage the challenges of caring for sicker patients in less time, of improving patient satisfaction during hospitalization, and of

improving the work environment for nurses to keep them on the job, they must have adequate resources. To these ends, Congress should ensure that Medicare payment bears a reasonable relationship to the cost of treating Medicare patients. There is no question that hospitals can respond to positive incentives, and there is also no question that continued Medicare payment rate deficiencies will eventually impair the quality of care available to Medicare beneficiaries and the public at large.

The following sections describe why the AHA believes there is a real and growing shortage of nurses in this country; what we think some of the causes are; what some hospitals are doing to minimize the effects of the shortage on their institutions; and what Congress can do to keep the shortage from growing to crisis proportions and to assure that hospitals can deal with the shortage effectively and without compromising patient care.

CAUSES OF THE SHORTAGE

Because nursing shortages have occurred periodically in the past, some believe that they are nothing more than temporary disturbances in the nursing labor market. But the shortage facing hospitals today seems to be different and harder to comprehend. More nurses are working than ever before. The supply of registered nurses reached an all time peak in 1985. Contrary to popular perception, few of these nurses are leaving the profession. Almost 80 percent of registered nurses are actively employed either full- or part-time as nurses, a very high rate of labor force participation among women-dominated professions. Of those not employed as nurses, only about 6 percent abandoned the profession, and few of the rest are looking for work. Nurses are not leaving hospitals for other settings in great numbers, either. The proportion of all working nurses who are employed by hospitals -- a little over two-thirds -- has been relatively constant for the past 30 years.

At the same time, the demand for nurses continues to exceed available supply. Recent data from the AHA's most recent Nursing Demand Survey, which was conducted during the winter of 1987, reveals that the perception among hospitals of a shortage of skilled nurses remains firm. Average hospital vacancy rates for registered nurses rose slightly between 1986 and 1987, to 11.3 percent nationally, and one-fourth of all hospitals report vacancy rates in excess of 15 percent. While there was a slight decline in those reporting a severe shortage of nurses through 1987, there were also fewer reporting "no shortage," and an increase in the proportion of hospitals reporting at least some shortage. Most hospitals claim difficulty recruiting nurses for most positions. Most hospitals were seeking medical/surgical nurses and skilled

registered nurses for intensive care units. More than two months are generally needed to fill these positions.

Some common assumptions about causes of the shortage are not borne out by current research. Although it is popularly believed that many nurses are being siphoned off to other settings or are leaving nursing for other professional career options, this does not seem to be the case. The shortage also is not merely a product of poor geographic distribution of nurses, because the unmet demand for nurses cuts across all geographic areas. In fact, though the supply of nurses relative to population tends to be higher in urban areas, more urban area hospitals report severe shortages. Neither is the shortage explained by a high turnover rate in hospitals. Because most nurses remain in nursing and continue to work in hospitals, turnover would affect vacancy rates but not the aggregate supply of nurses. Moreover, if turnover were the only determining feature of the shortage, hospitals would not report such difficulty filling positions.

REASONS UNDERLYING THE NURSE SHORTAGE

The AHA believes there are two factors contributing to the current shortage. First, hospitals are employing more nurses to do a wider variety of functions than in the past. Hospitals employ far more registered nurses relative to other staff than they did when PPS was implemented in 1983. When Congress created incentives for greater efficiency in the production of patient services, hospitals responded with cuts in their labor force, the single largest component of hospital variable costs. These cuts were made in the best possible places, where they were least likely to affect patient care.

Hospitals employ about 100,000 fewer people than they did in 1983, but almost 40,000 more nurses. Nurse-to-patient ratios have risen from 50 per 100 patients in 1970 to 91 nurses per 100 in 1986. Hospitals now have a much higher ratio of nurses to other hospital personnel, and, among the nurses, a higher proportion of registered nurses to licensed practical or vocational nurses. When Medicare was implemented, registered nurses comprised only one-third of a hospital's nursing service personnel; they now account for about 58 percent.

The higher proportion of registered nurses on the hospital staff is largely attributable to a widespread perception among hospitals that they are treating sicker patients than five years ago. In the AHA's recent hospital nursing personnel survey, increased patient acuity was reported by the vast majority of hospitals of all types, of all sizes, in all regions, and in both urban and

rural areas -- though especially in urban areas. Clearly with the decline in admissions since 1983, and a concomitant increase in outpatient services, many short-stay, low-cost, and low-intensity admissions have not taken place. Consequently, patients in the hospital are likely to be on average sicker and require more intensive services. Shorter lengths of stay also increase the intensity of patient care. Hospitals are under pressure to ensure that patients receive all the care they need during their hospitalization, but facilities have less time to prepare the patient for discharge and to search for appropriate post-hospital placement. More skilled personnel are needed to provide comprehensive patient care, including patient education, discharge preparation, discharge planning, and medical utilization and quality review, all of which require technical knowledge and sound clinical judgment.

The second factor suggesting more severe shortages in the future is that fewer people have been entering the profession since 1983. Enrollment declines have been sharp enough to prompt several major training centers to shut down their nursing schools. The American Council on Education noted a 50 percent drop since the mid 1970s -- most sharply since 1983 -- in first-year freshman women who plan careers in nursing. Declines in federal support for nursing schools and nursing students could mean further enrollment declines. In addition, with 1987 budget reconciliation law changes requiring Medicare to increase requirements for registered nurse staffing in nursing homes, the new demand from outside hospitals could create an additional drain on the nurse supply available to hospitals.

WHAT HOSPITALS ARE DOING

Hospitals are trying to find innovative ways to cope with the shortage of nurses. Within the limits of available resources, some are trying to attract nurses with higher salaries. Valley Community Hospital of Dallas, Oregon, has had some success reducing its turnover rate by creating a wage differential for undesirable night and weekend shifts. Some facilities are restructuring the role of the hospital nurse to make better use of the high skills offered by the registered nurses and confer routine and non-clinical functions on ancillary staff. Other institutions are attempting to improve the work environment and make nursing in the hospital more attractive to lower nurse turnover, improve recruitment, and contribute to attracting new entrants into nursing.

Introducing new structure to nursing delivery entails a major commitment on the part of the institution, but hospitals are rising to the challenge.

- Hartford Hospital, Hartford, Connecticut, has created a multi-level "clinical nursing assistant" program to provide specialized assistance to registered nurse staff by performing some of the non-clinical functions.

- Riverview Medical Center, Red Bank, New Jersey, implemented a collaborative model of nursing practice which, through integrated record keeping and "grand rounds" by a multi-disciplinary team of physicians, nurses, social workers, and physical therapists, makes the nursing role more attractive by increasing the nurse's responsibility for the patient's care plan, making better use of the nurse's clinical expertise, and improving communication among staff.

- The Boston-based New England Medical Center hospitals have undertaken an ambitious case-management program that uses the primary nurse to organize, direct, evaluate, and revise the care plan for patients throughout the stay in the institution and through other levels of care beyond the hospital stay.

- Cedars-Sinai Medical Center in Los Angeles has implemented a comprehensive retention and recruitment program designed not only to create a more congenial work environment but to meet the professional development needs of its nurses. In addition to a staff nurse advisory board, nurse productivity practice committee, and nurse recognition awards program, Cedars-Sinai has implemented specialized in-house clinical training programs, a mobile skills laboratory, and career advancement training.

- Memorial Mission Hospital in Asheville, North Carolina created its own critical care nurse training program for new nurse graduates to meet an unmet need for critical care nurses and to address the career development concerns of its own nurses.

Other hospitals provide child care for working parents to make it possible forsome of the many part-time nurses to increase their hours. One researcherhypothesizes that a marginal increase in the number of hours logged by the 500,000 part-time registered nurses -- representing over one-fourth of the nursing pool -- could substantially affect the supply of full-time-equivalent nurses.

CONGRESS' ROLE

But an individual hospital can only do so much to affect an industry-wide dysfunction in the nursing labor market, particularly if enrollment in nursing

schools continues to fall. Hospital efforts to make the nursing profession appear more attractive may help, but they cannot do it alone. There are two important roles for Congress to play.

In the long term, Congress must reassert its commitment to support for nursing education. Federal funding support for nursing schools and students fell from $160 million in 1973 to $56 million in 1988. Additional federal funding could help attract qualified individuals in undergraduate nursing programs or could be targeted to support educational mobility opportunities to enable licensed practical nurses to acquire the nursing education needed for registered nurse licensure. Funding and financial aid for entry level nurse education are essential but should not eclipse funding for advanced training to enhance the skill level of the nursing pool. AHA surveys indicate that a majority of hospitals have vacancies for nurse managers, and the need continues to grow for nurse specialists that can contribute in an increasingly technology intensive delivery system.

Funding for demonstration projects to test new nursing practice models and improve the working conditions of nurses, and funding to encourage the development of child care programs and parental leave that can increase the participation of part-time nurses are also worth considering. These could make a substantial contribution to alleviating the shortage.

Of course, making funds available to educate additional nurses will not solve the problem unless hospitals are able to pay nurses the competitive salaries needed to attract people into the profession. Adequate compensation, work environment improvements, and special programs for retention and recruitment of nurses, will clearly not be possible if hospitals are inadequately paid for delivering care. Congress can do a great deal in this regard in view of its role in financing health care services.

The principal thing Congress should do is ensure adequate Medicare payments to hospitals. Facilities should receive annual updates reflecting the inflation actually faced by hospitals. But, the actual update factors over the past five years have been consistently below HCFA's marketbasket estimate, creating a cumulative shortfall of more than 11 percent. In addition, even if the updates were at the level of the marketbasket calculation, Medicare rates would still be insufficient. Because HCFA computes the index using a blend of hospital and non-hospital wage data, increases in nurses wages are systematically underrepresented by current estimates of hospital inflation. Thus updates at even the marketbasket level would still understate actual

hospital inflation and impose additional downward pressure on nurses' wages. Congress should direct HCFA to base the labor component of the marketbasket on hospital wages alone rather than on a combination of hospital and non-hospital wages, and should ensure that Medicare price updates reflect actual increases in hospital inflation.

Now that Medicare PPS third year cost data are available, it is clear that despite increases in hospital productivity, increased case mix and higher intensity of services have driven per-case costs upward since the first year. Most analysts today, including the Prospective Payment Assessment Commission, project hospitals' FY 1988 PPS payments to be below costs, with negative margins in the aggregate. Hospitals cannot continue very long to absorb losses on such a large portion of patient revenue as Medicare represents. Hospitals will surely not be able to respond effectively to the nurse shortage when operating under a deficit.

In addition to ensuring adequate Medicare payments, Congress could help stimulate private-sector health insurance coverage for workers and their dependents, and could expand financing of care for the medically indigent who are unable to obtain private health coverage. The federal government must insist on adequate provider payment for Medicaid services using its increased flexibility in setting payment levels granted under 1981 budget reconciliation law.

CONCLUSION

Todays nursing shortage does not appear to be like other nursing shortages. Longstanding trends increasing hospital demand for nurses, including an increase in patients' average severity of illness and budget cuts that have forced reductions in the hospital labor force, have induced hospitals to increase registered nurse staffing relative to other hospital personnel. At the same time, for a variety of social, demographic, and economic reasons, fewer women are entering schools of nursing, threatening sharp declines in the nurse supply.

Hospitals are being asked to respond with higher wages and innovative management of nursing and ancillary personnel, and they are doing what they can. But hospitals are going to manage the challenges of providing for sicker patients in less time, of improving patient satisfaction during hospitalization, and of improving the work environment for nurses to keep them on the job, institutions must be given adequate resources. Hospitals have to find a way to reconcile these competing pressures. Congress can help by ensuring adequate Medicare payments.

Senator HEINZ. Thank you, very much. And I thank you for an excellent statement, and rest assured that I think there will be a lot of interest in both your and the National Association's testimony.

Mary Naylor.

STATEMENT OF MARY NAYLOR, PH.D., F.A.A.N., R.N., ASSOCIATE DEAN AND DIRECTOR OF UNDERGRADUATE STUDIES, UNIVERSITY OF PENNSYLVANIA, SCHOOL OF NURSING

Ms. NAYLOR. On behalf of the members of the American Association of Colleges of Nursing and the Pennsylvania Nurses' Association, I am pleased to have the opportunity to present testimony to this committee related to the nursing shortage.

Senator Heinz, your commitment to quality health care for the elderly is very well recognized and deeply appreciated by the nursing community. I had the good fortune to learn of this commitment first hand, as mentioned earlier, when I worked with your staff for several months in 1985 and 1986. As a result of this experience, I know that you and the members of this committee understand the pivotal role that nurses play in delivering quality, affordable health care.

An acute shortage of qualified nurses exists in this country, with far-reaching implications for the health of this Nation. This situation is compounded by a significant decrease in nursing school enrollments and a dramatic decline in the national pool of high school and college students indicating an interest in nursing. These major changes in the current and future supply of nurses are occurring at a time when the need for highly sophisticated, competent, caring nurses is more urgent than at any other period in nursing history.

A major factor contributing to clinically caring nurses today and for years to come is the rapid growth of the elderly population in this country, most notably, the frail elderly. An adequate supply of nurses willing and able to dedicate themselves to the special needs of populations such as the elderly is critical to the development of a cost-effective continuum of health services.

I come to the committee today, therefore, with a series of recommendations which are designed to assure quality health care for the elderly and for all citizens of this country by strengthening the nursing profession's ability to recruit and retain bright men and women. The Pennsylvania Nurses' Association will furnish this committee with documentation to support these recommendations.

My first set of recommendations are directed toward enhancing the work environment of nurses.

I believe that the Division of Nursing should support the demonstration and evaluation of innovative models of nurse managed care for the elderly and other high-risk patient populations who require an affordable continuum of quality health services including acute, transitional, and long-term care.

Nurse managed care presents opportunities for the nursing profession to address the issues of allocation of scarce resources, appropriateness and effectiveness of care, cost containment and professional accountability. Further, nurse managed care systems pro-

mote autonomy and job satisfaction. Nurses are uniquely qualified to coordinate and monitor the complex needs of those groups of patients who require managed care.

Second, the Division of Nursing should support the demonstration and evaluation of major changes in the organization and practice of nursing in hospitals which are designed to increase the retention of qualified nurses.

The 1987 American Hospitals Association Nursing Personnel Survey showed that 20 percent of nurses at the average hospital had been employed for less than 1 year. The AHA's Division of Nursing estimates that if 20 percent of the 800,000 nurses working in U.S. hospitals are recruited to a new work environment each year at an average cost of $20,000 per nurse, nurse turnover is responsible for an aggregate annual cost to hospitals of $3 billion. Improving nurse retention could go a long way toward reducing vacancies at the institutional level as well as contributing to improve quality of care through a more stable, experienced professional nursing staff.

A broad consensus has emerged in recent years that resolving the Nation's nursing crisis requires restructuring the organization and practice of nursing in hospitals. Both the National Commission on Nursing sponsored by the Hospital Research and Education Trust and the congressionally mandated study of nursing conducted by the Institute of Medicine, National Academy of Sciences concluded that nursing roles require restructuring to improve nurses' satisfaction with their work and make more efficient and effective use of the unique skills and expertise of nurses, as well as to retain experienced nurses in clinical care.

Since these two blue ribbon reports were issued in the early 1980's, some hospitals around the country have begun to experiment with various strategies to enhance the attractiveness of hospital nursing. However, few of these efforts have been adequately described, and there is almost no systematic evaluation of the impact of these innovative programs on nurse retention or cost.

Third, the National Center for Nursing Research should identify as a priority and receive additional funding for studies which involve cross industry comparisons of the use of various incentives and staffing patterns to enhance nursing staff retention.

There is little doubt that lack of control over working hours is the single most unattractive aspect of hospital nursing. Obviously, hospitals and nursing homes must have nurse coverage on a 24-hour basis. There are many other industries that operate on this basis who seem to have successfully addressed the 24-hour staffing requirement. A cross industry comparison of the costs and benefits of 24-hour staffing policies and practices as well as other labor practices would substantially improve our understanding of their potential applicability in hospitals.

The following recommendations are designed to support the education of nurses:

Hospitals, other employers of nurses, and schools of nursing should be supported in their efforts to provide incentives for diploma and associate degree nurses to pursue more advanced degrees in nursing, specifically the Bachelor's degree in Nursing and the

Master's degree in Nursing, because of the dramatic need for nurses with these levels of education in the workforce.

Major factors contributing to the increasing demand for nurses educated at the undergraduate and graduate levels include increased acuity and complexity of patients' needs in hospitals, nursing homes and home care settings resulting from the introduction of the prospective payment system, and continued technological advances in health care. Projected needs for full-time registered nurses with baccalaureate degrees are about twice the projected supply for 1990 and 2000. For nurses with graduate degrees, the requirements are about three times higher than the projected supply. This represents a deficiency of 619,000 nurses prepared at the undergraduate and graduate levels. Existing and new baccalaureate and graduate nursing programs would need to more than double their enrollments in order to achieve the desired number of professional nurses by the year 2000.

Hospitals, other employers of nurses, and schools of nursing should receive Federal and State support to establish work-study and work-grant programs designed to attract new students into the nursing profession.

This recommendation recognizes the unique nature of the population choosing nursing as a career, often older students with major family responsibilities and limited access to traditional financial aid options.

A work study program would enable students to work during the summer and school years as nurse assistants in hospitals, nursing homes, or other health care settings. This program could provide tuition support, and at the same time, enable students to develop essential skills in the care of special patient populations. A work-grant program would enable nursing students to devote more of their time to study by receiving tuition support while attending school. In return for tuition, students would agree to work for a period of time after graduation in hospitals, nursing homes, or other health care settings.

Third, the authorization of the Nursing Student Loan Program needs to be increased and restrictions currently associated with this program eased in order to more effectively address the financial burden of nursing students.

And finally, we need to increase advanced nurse training appropriations. Special priority should be given to those advanced nurse training programs that prepare clinical specialists and nurse practitioners for the care of patient populations with special needs including the elderly.

Today and in the foreseeable future, this Nation will face multifaceted problems in caring for our elderly, for the chronically ill and for those Americans who have limited access to health care. Recent research has demonstrated that nurses can provide quality, cost-effective care to many segments of the population—young mothers with very low birthweight infants, young men and women with AIDS, individuals with chronic mental and physical illnesses, and the frail elderly and their families. Nurses have made life and death differences in health care settings throughout the country. The nursing profession must continue to attract bright, committed

men and women to fully contribute to our Nation's quest for excellence in health care.

The health of Americans requires intelligent, sophisticated, and caring nurses to offer health services at the lowest cost and highest quality. Legislation must enable this to occur. Nursing is a national resource and properly used can significantly help to address the health problems we are facing today and anticipating tomorrow. Thank you.

[The prepared statement of Mary Naylor follows:]

88-594 - 89 - 3

Text of Testimony Given to
U.S. Senate Special Committee on Aging
6 April 1988
by Mary D. Naylor, Ph.D., F.A.A.N., R.N.
Associate Dean and Director of Undergraduate Studies
University of Pennsylvania, School of Nursing

Introduction

On behalf of the members of the American Association of Colleges of Nursing and the Pennsylvania Nurses' Association, I am pleased to have the opportunity to present testimony to this Committee related to the nursing shortage. Senator Heinz, your commitment to quality health care for the elderly is well recognized and deeply appreciated by the nursing community. I had the good fortune to learn of this commitment first hand when I worked with your staff for several months in 1985 and 1986. As a result of this experience, I know that you and the members of this Committee understand the pivotal role that nurses play in delivering quality, affordable health care.

An acute shortage of qualified nurses exists in this country, with far reaching implications for the health of this nation. This situation is compounded by a significant decrease in nursing school enrollments and a dramatic decline in the national pool of high school and college students indicating an interest in nursing. These major changes in the current and future supply of nurses are occurring at a time when the need for highly sophisticated, caring nurses is more urgent than at any other period in nursing's history.

A major factor contributing to the increased demand for competent, clinically caring nurses today and for years to come is the rapid growth of the elderly population in this country, most notably, the frail elderly. An adequate supply of nurses willing and able to dedicate themselves to the special needs of populations such as the elderly is critical to the development of a cost-effective continuum of health services.

I come before this Committee today, with a series of recommendations which are designed to assure quality health care for the elderly and for all citizens of this country by strengthening the nursing profession's ability to recruit and retain bright men and women. The Pennsylvania Nurses' Association will furnish this Committee with documentation to support these recommendations.

A. Nursing Practice

My first set of recommendations are directed toward enhancing the work environment of nurses.

1. The Division of Nursing should support demonstration and the evaluation of innovative models of nurse managed care for the elderly and other high risk patient populations who require an affordable continuum of quality health services including acute, transitional and long-term care.

Nurse managed care presents opportunities for the nursing profession to address the issues of allocation of scarce resources, appropriateness and effectiveness of care, cost containment and professional accountability. Further, nurse managed care systems promote autonomy and job satisfaction. Nurses are uniquely qualified to coordinate and monitor the complex needs of those groups of patients who require managed care.

2. The Division of Nursing should support the demonstration and evaluation of major changes in the organization and practice of nursing in hospitals which are designed to increase the retention of qualified nurses.

The 1987 AHA Hospital Nursing Personnel Survey showed that 20 percent of nurses at the average hospital had been employed for less than one year. The AHA's Division of Nursing estimates that if 20 percent of the 800,000 nurses working in U.S. hospitals are recruited to a new work environment each year at an average cost of $20,000 per nurse, nurse turnover is responsible for an aggregate annual cost to hospitals of $3 billion (Connie Curran, AHA). Improving nurse retention could go a long way toward reducing vacancies at the institutional level as well as contributing to improved quality of care through a more stable, experienced professional nursing staff.

A broad consensus has emerged in recent years that resolving the nation's nursing crisis requires restructuring the organization and practice of nursing in hospitals. Both the National Commission on Nursing sponsored by the Hospital Research and Education Trust and the Congressionally mandated study of nursing conducted by the Institute of Medicine, National Academy of Sciences concluded that nursing roles require restructuring to improve nurses' satisfaction with their work and make more efficient and effective use of the unique skills and expertise of nurses, as well as to retain experienced nurses in clinical care.

Since these two blue ribbon reports were issued in the early 1980's some hospitals around the country have begun to experiment with various strategies to enhance the attractiveness of hospital nursing. However, few of these efforts have been adequately described and there is almost no systematic evaluation of the impact of these innovative programs on nurse retention or costs.

3. The National Center for Nursing Research should identify as a priority and receive additional funding for studies which involve cross industry comparisons of the use of various incentives and staffing patterns to enhance nursing staff retention.

There is little doubt that lack of control over working hours is the single most unattractive aspect of hospital nursing. Obviously, hospitals and nursing homes must have nurse coverage on a 24 hour basis. There are many other industries that operate on this basis who seem to have successfully addressed the 24 hour staffing requirement. A cross industry comparison of the costs and benefits of 24 hour staffing policies and practices as well as other labor practices would substantially improve our understanding of their potential applicability in hospitals.

B. Nursing Education

The following recommendations are designed to support the education of nurses.

1. Hospitals, other employers of nurses and schools of nursing should be supported in their efforts to provide incentives for diploma and associate degree nurses to pursue more advanced degrees in nursing (B.S.N. and M.S.N.) because of the dramatic need for nurses with these levels of education in the workforce.

Major factors contributing to the increasing demand for nurses educated at the undergraduate and graduate levels include: increased acuity and complexity of patients' needs in hospitals, nursing homes and home care settings resulting from the introduction of PPS and continued technological advances in health care. Projected needs for full-time registered nurses with baccalaureate degrees are about twice the projected supply for 1990 and 2000. For nurses with graduate degrees, the requirements are about three times higher than the projected supply. This represents a deficiency of 619,000 nurses prepared at the undergraduate and graduate levels. Existing and new baccalaureate and graduate nursing programs would need to more than double their enrollments in order to achieve the desired number of professional nurses by the year 2000.

2. Hospitals, other employers of nurses and schools of nursing should receive federal and state support to establish work-study and work-grant programs designed to attract new students into the nursing profession.

A work-study program would enable students to work during the summer and school years as nurse assistants in hospitals, nursing homes or other health care settings. This program could provide tuition support, and at the same time, enable students to develop essential skills in the care of special patient populations. A work-grant program would enable nursing students to devote more of their time to study by receiving tuition support while attending school. In return for tuition, students would agree to work for a period of time after graduation in hospitals, nursing homes or

other health care settings. This recommendation recognizes the unique nature of the population choosing nursing as a career--older students, often with major family responsibilities and limited access to traditional financial aid options.

3. The authorization of the Nursing Student Loan Program (NSLP) needs to be increased and restrictions currently associated with this program eased in order to more effectively address the financial burden of nursing students.

The increased funds for the Nursing Student Loan Program could be earmarked as a payback option. Students who receive monies from this Program could elect to pay the loan back through traditional means or through service to special populations. Currently, students can receive a maximum of $10,000 ($2,500/per year for up to four years) under this fund. The NSLP has had no new monies added to this revolving fund for the past several years. This program has been reauthorized to include only those in "exceptional financial need." To receive funds, students' resources must not exceed 50% of the costs of attending school. Because of these and other restrictions, many schools of nursing no longer participate in this program. Increased support for and restructuring of the NSLP could significantly ease the financial burden of nursing students.

4. My final recommendation is to increase advanced nurse training appropriations. Special priority should be given to those advanced nursing education programs that prepare clinical specialists and nurses practitioners for the care of patient populations with special needs including the elderly.

Summary

Today and in the foreseeable future, this nation will face multifaceted problems in caring for our elderly, for the chronically ill and for those Americans who have limited access to health care. Recent research has demonstrated that nurses can provide quality, cost-effective care to many segments of the population--young mothers with very low-birthweight infants, young men and women with AIDS, individuals with chronic mental and physical illnesses and the frail elderly and their families. Nurses have made life and death differences in health care settings throughout this country. The nursing profession must continue to attract bright, committed men and women to fully contribute to our nation's quest for excellence in health care.

The health of Americans requires intelligent, sophisticated and caring nurses to offer health services at the lowest cost and highest quality. Legislation must enable this to occur. Nursing is a national resource and properly used can significantly help to address the health problems we are facing today and anticipating tomorrow. Thank you.

Senator HEINZ. Mary, thank you very much. That was excellent. Dr. Willging.

STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE DIRECTOR, AMERICAN HEALTH CARE ASSOCIATION

Dr. WILLGING. Thank you, Mr. Chairman. We have prepared a written statement. With your permission, I will only briefly summarize it today.

Senator HEINZ. Without objection, the entire statement will be part of the record.

Dr. WILLGING. Thank you, Mr. Chairman, for the opportunity to testify today. I represent 9,000 nursing homes across the country as the executive director of the American Health Care Association. One slight correction, Mr. Chairman, we represent both nonproprietary and proprietary nursing homes, and in fact, are the largest nonproprietary representative body in the city of Washington, DC, as well.

Senator HEINZ. Which do you have more of?

Dr. WILLGING. We have more proprietary nursing homes because the industry is structured more toward proprietary homes; 70 percent of all nursing homes are investor homes.

Ten days ago, Mr. Chairman, the ninth largest nursing home company in the United States filed bankruptcy in the bankruptcy courts in California. For the last three-quarters, the largest nursing home care company in the United States has posted losses. Hillgate, a company headquartered here in the State of Pennsylvania, geriatric and medical centers, has begun to post losses.

I raise this not to ask for sympathy for the financial plight of nursing homes. That clearly is not your concern. That is our concern. I raise it, however, in terms of a basic premise that needs to be made. The nursing home industry is in the most precarious financial position it has ever experienced in its 20- or 30-year history. That precarious financial situation is largely a function of the nursing shortage. And ultimately, and this is where you are concerned, Mr. Chairman, the industry, in the disarray currently being faced by the nursing home industry can only ultimately see the impact on the residents requiring service.

I'd like to make that statement and explain it in some detail. I'd also like to suggest that when one looks to the nursing shortage in this country, one looks for the potential solutions of that shortage, one has to recognize some very basic differences between the acute care setting and the long-term care setting. We are two completely different industries, and our concerns, our needs and then potentially the solutions are equally different.

First, how is the nursing shortage so seriously bankrupt, essentially, in the nursing home industry, and how does that impact ultimately on patient care?

Essentially when a nursing home, be it a corporation, an individual proprietary facility, a non-proprietary facility, cannot achieve the levels of nursing required, both in terms of its own requirements for high quality care, as well in terms of as basic Federal and State standards, when those nurses are not available, it looks

to the temporary nurse, it looks to the pool for its registered nurses.

The second largest nursing home corporation is Hill Haven. It houses a large number of facilities on the east coast. It bills 40 percent of its nursing hours every year to a pool of registered nurses, 40 percent, at premiums, two, three, four times, in some cases, with very difficult requirements, two, three, and four times times the rate that we pay the staff nurses.

An industry which is traditionally operated on very narrow margins, and I recall testifying before you once before Mr. Chairman, and you suggested that the grocery store industry had even narrower margins, but I think we would agree 1 or 2 percent is cutting it very tight.

When it then reaches an unanticipated high cost, energy, or in this case, the nursing issue, obviously, it has difficulties, and those difficulties have become clearer and clearer over the past few years, this, even prior the Omnibus Budget Reconciliation Act back in 1987, which has placed major new staffing requirements on the nursing industry. And staffing requirements, I think we would all agree, are all at the root. It's almost intolerable, given the acuity levels of today's nursing home patients, that facilities in certain States can get by with only one shift of nurses and that just licensed personnel.

Indeed, we were disappointed, Mr. Chairman, not to have been able to support the desire expressed both by you and your colleague, Congressman Walters, and the State of Pennsylvania perhaps moved even beyond what was ultimately enacted by Congress, but as we looked at the shortage in terms of supply, and as we look at the difficulties in terms of reimbursement, we recognized that we were going to have a difficult enough time adhering even to the fairly dramatically increased requirements that were contained in OBRA 1987, much less, despite are own ultimate desire, to remove 24-hour registered nursing requirements.

Indeed, I can guarantee today, Mr. Chairman, that once the nurse staffing requirements of OBRA are finally implemented in the early 90's, we will see massive numbers of nursing homes in this country terminating the Medicare and Medicaid not because of a lack of desire, but simply because the nurses are not there. Even when the nurses are there, the nature of the medical reimbursement program does not allow sufficient reimbursement to pay the nurses' salaries.

Let me, if I could, briefly move to what I think some of the solutions have got to be.

As I suggested, the nursing home industry is dramatically different in its utilization of nursing personnel than the acute care industry. Most nurses in the acute care settings are registered nurses. Most nurses in the long-term care setting are licensed practical nurses or licensed vocational nurses. In some States, for example, Oklahoma, the ratio of LPN's to RN's is 5 to 1. LPN's are the lifeblood of the long-term care industry, not necessarily by preference, but again, as a result of the marketplace within which it has had to operate.

And as we look to solutions, if we look to solutions dealing only with the availability of registered nurses in this country, the solu-

tions have not helped long-term care. The solutions have not impacted favorably on the care provided our residents until we can deal with the issues of supply of RN's and the reimbursements.

Second, as we look to solutions, let us not ignore the advances and innovations that have taken place in the academic setting in terms of the workplace. The demonstrations that we have. They are important. But as you have suggested in your own public statements, ultimately this Nation has got to deal with the underlying issue, the underlying issue of resources.

I'm always amazed at those that would have us believe that the nursing shortage issue is a highly complex issue. It is not a highly complex issue; 20 or 30 years ago, young women, it was considered primarily a women's profession, had two or three choices when looking for fulfilling a rewarding professional career. They could become teachers, they could become either nurses, some of the Sisters told me they could become nuns. In this country that has changed. Thank God, it has. And now, women have as many opportunities as do their male counterparts. One of the basic differences is that nursing still will reward inadequately both financially and in terms of professional esteem.

We have got to deal with the issue of resources. There are no two ways around that problem.

And when we get to the area of long-term care, particularly in the nursing home industry, we need to recognize that until we are along at an even keel with the rest of the health care sector, we will never be able to recruit, attract, and retain the nurses we need. We have got to as a Nation ask ourselves whether we will continue to allow State Medicaid programs to balance their budgets on the back of long-term care residents.

The data is explicitly clear, Mr. Chairman. The average charge in a nursing home makes 23-percent less than the average charge nurse in a hospital. The average staff nurse in a nursing home makes 19-percent less than a staff nurse in a hospital. And after we in the nursing home industry have been able to deal with the psychological hurdles that a potential candidate brings to bear when looking at the possibility of working in a nursing home, and those psychological hurdles you know about do spring up, the perceptions of nursing homes are not that favorable in this country. The same is true of nurses.

And once we have attracted that nurse, once we have shown her that with her experience that she will only make 80 percent of what she could make in a hospital, that is one of our most critical issues, and one we have got to urge you and your colleagues to deal with, a much more systemic, much more economically based issue that until it is resolved, will continue to not just provide constraints in the resolution of this issue, but indeed exacerbate it. Thank you very much.

[The prepared statement of Dr. Willging follows:]

Statement of the
American Health Care Association

ADDRESSING THE NURSING SHORTAGE

by

Paul R. Willging, Ph.D.
American Health Care Association

before the

SENATE SPECIAL COMMITTEE ON AGING

Philadelphia, Pennsylvania
April 6, 1988

ahca
American Health Care Association 1200 15th Street, NW, Washington, DC 20005 (202) 833-2050
For Further Information Contact:

Sara Thomasson

Good morning. I am Dr. Paul Willging, executive vice president of the American Health Care Association (AHCA), the largest organization representing America's long term care providers. AHCA's membership exceeds 9,000 nursing homes which provide care for over 950,000 chronically ill patients each day.

It is, indeed, a pleasure to appear before your field hearing, Mr. Chairman, to discuss what we in the industry consider to be one of the most important issues facing the long term care industry -- the shortage of nurses. I am especially pleased

that you have chosen to examine this problem because of your strong past support for increasing nurse staffing requirements for long term care facilities. Now that Congress has raised nurse staffing standards in the recent reconciliation bill, I commend you for your interest in assuring that the supply of nurses is sufficient to meet those new federal nursing requirements.

Let me first say that the nurse shortage problem is not just a short term or cyclical phenomenon for the long term care industry. The nurse shortage problem is real, it is chronic, and it exists in all geographic areas where long term care is provided. And frankly, it is handicapping our ability to provide quality care.

Let me document our problems with a few details. Much concern has been expressed about the registered nurse (RN) vacancy rate in hospitals which has risen to 13.6 percent. A recent survey of our membership revealed that 58 percent of all long term care facilities reported vacancies for RNs. One-third indicated a need for RNs just to meet current minimum federal standards for staffing. Yet the shortage is not just limited to RNs. Seventy-eight percent of long term care facilities indicated a significant shortage of RNs in their service areas, and 79 percent reported a shortage of licensed practical nurses (LPNs). Recruitment has become much more difficult than in the past, and almost one-half of our member facilities report it takes over three months to fill RN vacancies.

Most deficiencies found by state and federal surveyors inspecting nursing homes relate to lack of adequately prepared staff. In light of the new staffing requirements recently enacted, we are very concerned that staffing pressures will only worsen.

How are nursing homes coping with the nurse shortage crisis? Staff shortages and high turnover have forced long term care facilities to rely more heavily on nursing pool agencies for temporary employees. In a recent Massachusetts study, almost two-thirds of long term facilities in the state reported they rely on nursing pools to cover RN vacancies. One-third indicated they are forced to use them "frequently." This is not a favorable

trend, and there is little doubt that it impacts negatively on the quality of care.

Short-term employees do not provide the continuity that is an essential part of quality care for long-term patients. Temporary nurses often have inadequate training, are more expensive, and often are not available for weekend and other undesirable shifts. Clearly, nursing pools are not a viable replacement for qualified and trained staff that have a stake in the quality of care provided to residents.

A number of state studies document rather dramatically the growing problem long term care providers are having with nursing pools. Until recently, these agencies had assumed a relatively minor and useful role in assisting nursing homes and other heath care providers with their short-term staffing needs. The nursing shortage has changed the nature of the marketplace relationship considerably.

Now, nursing pools compete for scarce personnel driving up the hourly charge for pool nurses to the point of double or even triple that of in-house nurses. Pool rates not only have profound impacts on labor costs incurred by facilities, but such salaries create resentment among staff nurses who work side-by-side with pool nurses earning substantially more for the same job. According to a recent Florida study, projections estimate that the additional costs of nursing pools and some overtime will cost the state Medicaid program as much as $15.7 million during the 1988-89 fiscal year.

Alternatively, nursing homes, as well as hospitals, are looking to other countries with commensurate nursing education programs, such as Canada, Ireland, the United Kingdom and the Philippines, to recruit RNs to work in their facilities. It often takes two years for a foreign nurse to relocate in this country, and clearly this is not a viable long-term solution to the nursing shortage problem.

The future availability of nursing personnel is not promising either. The most recent report on nursing from the Department of Health and Human Services revealed that in 1983, 121,000 professional nurses worked in nursing homes, and it predicts that in 1990, 500,000 will be needed. By the year 2000, over

one million RNs will be needed in long term care facilities. Bear in mind that these projections do not reflect the new nurse staffing requirements signed into law in December. Yet, all evidence points to declining enrollment in nursing programs, declining interest in nursing careers among college students, and a shrinking pool of females age 18-24 -- the population most likely to enter the nursing profession.

The proportion of incoming freshman who are interested in nursing as a career declined by 50 percent in the last decade. As a result of declining interest in nursing, many of the three-year diploma schools, which supply 41 percent of the nation's working RNs and 60 percent of the long term care RNs, have closed. In fact, based on current enrollment and attrition statistics, American colleges will graduate more physicians than degreed nurses in 1990.

While there are more nursing homes than hospitals in this country and more nursing home patients than acute hospital patients, only 7.1 percent of all employed RNs work in nursing homes. Yet the need for RNs is increasing more rapidly in long-term health care than any other health field -- the projected ratio of nurses in the year 2000 employed in hospitals versus nursing homes is 40 to 36 percent. Although future growth in nursing homes appears to be in long-term care, it has been difficult to attract RNs into the nursing home setting. Traditionally, nursing homes have been the practice setting of last choice for RNs, despite the great need for RNs in long term care facilities.

The etiology of our nursing shortage is complex. From our view, however, two major factors are paramount and must be addressed if we are to find workable solutions. First, health care, especially long term health care, is predominantly publicly financed. Federally- and state-imposed rates determine our parameters for nurses' salaries. These salaries are, by and large, seriously inadequate, especially for experienced nurses, and in view of the other more lucrative options open to nurses. Nursing homes, with their lower salary levels, have traditionally found it difficult to compete with hospitals. The explosive

growth in alternative health care delivery systems and community-based treatment settings makes competition for already scarce RNs even more intense.

Salary data provide insight into the recruitment problem. RNs in nursing homes earn an average of 23 percent less as head nurses and 19 percent less as staff nurses than those in hospital settings. The laws of economics have not been repealed for health care. If we do not adequately compensate our professional staff, we will be without that professional staff to care for the elderly and chronically ill in nursing homes. As long as long term care providers are locked into historical rates set in a cost-conscious environment, we will continue to have difficulty attracting and keeping the most capable nurses. I am suggesting that the very principles of health care financing must be revised with an eye toward quality, not just budget consciousness.

Second, finances aside, we, as employers and consumers of health care, must treat nurses as valuable resources. We must give these professionals the respect they deserve and a supportive work environment in which they can practice to their potential. We must give them the resources needed to deliver quality nursing care. We must minimize paperwork burdens and non-nursing functions and let nurses concentrate on assessment of patient needs, planning, coordination and delivery of patient care.

Several legislative proposals have been offered this year to address the nursing manpower shortage. I applaud these efforts and, in addition, I would like to suggest other potential legislative initiatives for your consideration.

Legislation introduced by Senator Kennedy and passed by the Senate, S. 1402, and its House companion introduced by Congressman Wyden, has two especially attractive provisions. First, the bill establishes nurse recruitment centers where we can target junior high, high school, college and older candidates with information on the nursing profession and nursing education programs. Second, the bill would expand the valuable work of the Robert Woods Johnson Teaching Nursing Home Program and encourage schools of nursing to launch special efforts in gerontological nursing and establish nursing homes as a clinical setting.

Support for LPN Programs

Licensed practical and vocational nurses, (LVNs) are the lifeblood of long term care facility nursing services. They are hands-on, bedside nurses that provide much of the direct patient care in nursing homes. We are alarmed at efforts to discontinue LPN educational programs and to limit the practice of LPNs and LVNs. We recommend public financial support of successful licensed practical-vocational nurse educational programs. We further recommend that federal statute and regulations not limit, in any way, the scope of service of these nurses. Rather, governing of the practice of nursing should remain at the state level.

Permit Qualified Foreign-Trained Nurses to Practice in the U.S.

As an interim, temporary measure to meet nursing home patients' nursing needs, many long term care providers are looking outside the boundaries of this country for nursing staff. The barriers and red tape associated with recruiting foreign-trained nurses are formidable. AHCA respectfully requests consideration of policies which would streamline the entry of qualified nurses into this country. We are not suggesting waiving basic educational, testing or salary safeguards built into the process of utilizing foreign professionals. We are suggesting an examination of the guidelines and barriers to nurses from such countries as Canada, the United Kingdom and Ireland, where nurses receive comparable education and are interested in working in America.

Loan Forgiveness for LTC Nurses

Years ago, student nurses who received their education through the federal Nurse Training Act loan program were able to cancel up to half of their student loans by working in certain clinical settings. We believe this idea should be renewed and aimed at practice in long term care facilities because of the special problems we have in attracting new graduates. This program would help the overall supply of nurses by supporting students for whom financial limitations pose a barrier to nurse education. It would help schools of nursing by helping to recruit

from student experiences and greater professional visibility. They would also serve as important mechanisms for needed faculty development activities and increased program emphasis on gerontological nursing.

Wage Pass-Through

Additional educational funding itself is an insufficient response to attracting and retaining nurses in nursing homes if facilities are not adequately reimbursed for the care they deliver, thus enabling them to pay competitive salaries. In order to pay competitive salaries, AHCA supports a wage pass-through concept that a number of states are in the process of pursuing. States should be required to adjust their Medicaid rates to provide a direct pass-through for wages to allow nursing home nurse salaries to be raised to parity with hospital nurse salaries. We feel this is the most significant action that Congress could undertake to force the Medicaid payment system to allow a decent wage for nursing home nurses -- a wage that is high enough to compete with other professionals and commensurate with their skills and knowledge.

Mr. Chairman, I would like to commend you for your timely hearing on the nursing shortage crisis. The availability of nurses is critical to the ability of nursing homes to provide for the present and future long term care needs of our elderly, additional bright candidates. And, I assure you, the financial incentive would benefit the patients and residents needing care in America's nursing homes.

The Need for LTC Clinical Practice in Nursing Education

The lack of involvement between schools of nursing and nursing homes is an important factor in the lack interest among nursing students in nursing home careers. When faculty members do not advocate the importance of gerontological nursing and nursing students have no clinical experience in long term care settings, it is rare that nursing students select nursing homes as their desired practice setting.

We advocate expanded federal funding of education programs that encourage clinical affiliations between nursing schools and nursing homes, from university baccalaureate degree programs to community college associate degree nursing programs. Nursing school affiliations would bring a new source of potential recruits to the nursing home setting because the familiarity of the setting and I look forward to working with you in your efforts to address this serious health care problem.

Senator HEINZ. Thank you very much, Paul. Dr. McNeal.

STATEMENT OF GEORGE McNEAL, M.D., CHIEF OF STAFF, VA MEDICAL CENTER, PHILADELPHIA, PA

Dr. MCNEAL. Thank you for inviting me. Because of the hour and because of the excellent testimony, I would just like to comment on my testimony rather than reading it in its entirety. So with your permission, I would like to submit it.

Senator HEINZ. Without objection, your entire testimony will be part of the record.

Dr. MCNEAL. I would like to focus on the Philadephia VA Medical Center and its up-coming efforts to meet the need of our aging population. We are a tertiary care medical center. We have about 500,000 to 550,000 veterans that we are concerned with. Of those, about 25 percent are 65 or older. That's about 140,000. By 1992, we expect that number to rise to 286,000.

Other witnesses have spoken to the factors that are related to the supply of nurses, and so I won't mention those. I will focus on what is an on-going project here.

We have, coming on line in less than 1 year, a 240-bed nursing home. In addition, we have under construction also a clinical addition. These will raise our total number of beds to 768, of which 40 percent will be in the extended care area, that is, intermediate care, and as I've alluded to, 240 beds in a nursing home.

I think that in the public sector we have to be mindful of the public trust, and it is my perception that we can not be out of the leagues in terms of nurses' salary. Our salaries are really tagged to wage surveys of the community, and we try to meet the average. That puts us in the position of lagging in terms of competitiveness, and being perhaps in the 50 percentile as far as competitiveness on salary.

We've had to turn then to trying to make our environment more attractive to nurses, specifically with regard to the nursing home. It is our decision to make it a teaching nursing home affiliated with the School of Nursing at the University of Pennsylvania. We will offer graduate programs for nurses. We plan to have teaching at all levels in that environment, so it will really be a model, and a continuation of models that are already in place throughout the country.

Also, our emphasis in our nursing home will be on rehabilitation. We recognize that there will be some patients for which it will be their home, but the major thrust will be in rehabilitation and returning those veterans to their communities.

We have tried, then, within this framework to be as creative as we possibly can, in attracting and retaining nurses in terms of scholarships, of stipends for graduate nurse technicians, trying to create innovative rolls for nursing such as nurse administered clinics, and clinical specialists. We have experimented with shifts trying to make them more attractive to single parent families.

We will have over 151 positions that we will have to fill in our nursing home, and it is through these mechanisms that we hope to be not only competitive but successful.

I would say in conclusion, that obviously there is a nursing shortage. We are part of a public sector. The rules of public policy that govern us is slightly different than the private sector. I would say that we have to compete largely in terms of job satisfaction, enhancement, career opportunities, and professional awards for upward mobility. Thank you.

[The prepared statement of Dr. McNeal follows:]

WRITTEN TESTIMONY TO BE PRESENTED BEFORE

THE SENATE SPECIAL COMMITTEE ON AGING

WEDNESDAY APRIL 6, 1988

PHILADELPHIA, PENNSYLVANIA

1. The Philadelphia VA Medical Center finds itself in a very unique position within the Delaware Valley. It is the primary tertiary care facility for 550,731 Veterans, approximately 25% or 140,000 of whom are aged 65 or older. By the year 1992 this number will increase to 286,000. These veterans are now at the age where health care is a primary and very difficult issue in their lives.

2. As the veteran population ages, new and dramatically different methods of caring for them must be created. This involves a medical and nursing staff not only skilled in caring for geriatric patients, but also very much interested in geriatric and extended care programs

3. The demands placed upon a nurse caring for geriatric and extended care patients is much different than those caring for acutely ill patients. Physical and mental outcomes are not as dramatic. Improved patient outcomes take much longer to achieve. The geriatric and extended care veteran patient requires a special kind of nurse that is more difficult to recruit.

4. Not only do we find the "pool" of nurses becoming smaller through competition from new career fields, but we also find that the traditional role of the nurse within the health care system is changing. Nurses, with their knowledge and experience of the medical field, find many new careers are open to them. Some careers outside the traditional nursing role are in law, insurance, and automated data processing. Within the medical field, nursing roles are expanding to include educational and teaching roles, clinical practice, independent practice, quality assurance, risk management, and review of the utilization of hospital services.

5. Within our geographic area, there are over 69 hospitals and acute care medical facilities. In fact, this area has one of the largest numbers of such facilities in the entire nation. The available "pool" of nurses is shared among these facilities. When one facility creates a new innovative program that attracts nurses another facility within the area will lose nurses because the "pool" remains constant. In fact, this "pool" becomes smaller each year due to closures of nursing programs and schools and the expanded roles for women in the workforce.

6. The problems created by the nursing shortage for the Philadelphia VA Medical Center in meeting the health care needs for our growing aging patient population can be best illustrated by our Nursing Home and Clinical Addition Projects. Currently under construction is a 240 Bed Nursing Home Care Unit and a Clinical Addition to the main facility. At the completion of these projects, the Philadelphia VAMC will have a total of 768 beds, 40% of which will be extended care beds. This will create a very significant increase in not only the need for additional nursing staff, but nursing staff of a particular kind. The Nursing Home Care Unit will require an additional nursing staff of over 151 FTEE. The total allowable nursing staff for the Philadelphia VAMC will increase from the current level of 358 FTEE to 509 FTEE. Even today, however, in staffing for acute units only, we consistently have approximately 20 nursing vacancies. All of these positions must be filled from the nurses available within our geographical area.

7. The Philadelphia VAMC must overcome many limitations in recruiting for this new nursing staff. The average salary and fringe benefit rates are generally lower even when special salary rates are considered. In addition, we are not able to offer other benefits which are extremely attractive to today's working and single parent families. Those benefits include totally paid health benefits and total tuition reimbursement. These are some of the issues which create difficulty for our recruiting.

8. In order to be competitive in attracting nurses, we have become as creative as possible. At the Philadelphia VAMC we are using several different approaches.

While limited in comparison to our neighbor hospitals, we offer financial assistance and tuition reimbursement to our nursing staff. The VA has scholarship programs for both future nurses and nurses who wish to expand their knowledge. We understand that the VA has proposed legislation to expand tuition reimbursement to include courses leading to a degree in nursing.

The VA has funded a clinical practicum in gerontology at the graduate level.

Our Integrated Hospital Computer System allows our nursing staff to devote more time to direct patient care.

We have innovative role assignments such as nurse administered clinics and clinical specialist positions. We have allowed creative staffing patterns where, rather than the typical eight hour shift, the nurse may work an expanded twelve-hour tour thus giving more time for family life. There is a great deal of attention focused on improving the distribution of workload (outside of the specialty areas) so that no one unit has the most critical cases. By using nursing staffing guidelines, we are able to rearrange staff to even more appropriately staff specific units.

We are in the process of opening an intermediate care unit which will permit more appropriate staffing, not only within extended care, but for acute care as well.

We offer special salary rates for nurses and also have evening and night differential pay. The Philadelphia VAMC maintains an aggressive incentive awards program.

As previously stated, we are constructing a 750,000 square foot Clinical Addition which will support all of our Outpatient Services as well as Operating Suites, ICU's, Laboratory, Radiology and other support services. This addition will make our physical facilities an exciting and modern medical center in which to work.

Due to open in one year is a 240 bed Nursing Home Care Unit. This will greatly increase the capacity to provide for the rehabilitative and extended care needs of our aging veteran population in our catchment area and offers new career opportunities for nurses.

Although parking is temporarily a severe problem, it will soon be improved with the addition of a 530 car parking garage currently under construction.

Lastly, the Veterans Administration is able to offer to nurses the opportunity to develop their careers in the largest medical system in the free world. A nurse joining the Philadelphia VA Medical Center has mobility throughout the continental United States, Puerto Rico, Alaska, and Hawaii.

9. In summary, while we recognize that there is a true nursing shortage that effects all health care institutions in the Delaware Valley, the impact on the Philadelphia Veterans Administration Medical Center is more severe. The information that I have presented is an indication of what steps we have taken to increase our ability to retain nurses and compete more effectively in recruiting new nurses. We remain concerned however, about our ability to maintain an adequate workforce, particularly with the facilities that are coming on line.

Senator HEINZ. Let me ask Mr. Pepper. Mr. Pepper, we had a discussion in the previous panel, and you mentioned in your testimony the issue of DRG rates and the hospital market basket does not adequately reflect nursing costs and wages. The Prospective Payments Commission, however, contends that the market basket is sound and has said in written testimony that the adjustments of the DRG rates or hosptial market basket to reflect nursing costs would have a minimal effect on hospital reimbursement. How much of a difference do you think a nursing adjustment would make, and would it be worth doing if it had only limited payoff?

Mr. PEPPER. Sir, I know that the Government agencies do not always agree with our industry analysis of what is adequate payment and what is not adequate payment. And we do not have time to get into that agrument. However, certainly Medicare reimbursement is inadequate. Over the last 5 years it's been about 11 percent of the cumulative——

Senator HEINZ. That's not what I was asking about. I was asking about the adjustment or——

Mr. PEPPER. If it were adjusted, how much of an adjustment would you need?

Senator HEINZ. I'm not talking about the update. I'm not talking about the annual update. I'm talking about whether within the restraints that have occurred almost without exception for each of the last 3 or 4 years, having a nursing adjustment, would that make any difference? I understand we all want more money.

Mr. PEPPER. Yes, sir.

Senator HEINZ. But I'm talking about——

Mr. PEPPER. Let me see if I can understand your question. Is your question whether if there were a specific nursing adjustment, would it make a difference or whether——

Senator HEINZ. Yes. ProPAC says it would not make a difference. Maybe you haven't looked into that. If you have not had the chance to look into it, I'll go on to my next question.

Mr. PEPPER. I think given the time you should go on to your next question, because it would be a matter of how much.

Senator HEINZ. Maybe you can look into that and let us know.

Mr. PEPPER. We would be delighted to comment.

Senator HEINZ. All right. Another comment that ProPAC made was this, that in the early days of the Prospective Payment System, DRG's, hospitals cut back on practical nurses, orderlies, and expanded the responsibilities of the RN, which is what our first panel testified to. To what extent is the hospital's need for more registered nurses simply a result of that kind of cutback to lower cost of either nurses or other support personnel?

Mr. PEPPER. That's an interesting theory, and we've had some testimony to that effect. As a hospital administrator, I will tell you that that most hospital administrators do whatever they can to make sure that their RN's are not doing tasks that are not directly related to patient care. One of the great problems, however, is that accreditation standards, regulatory standards and so forth increased the documentation that the nurses must do along with the malpractice climate. So that nurses today are spending a great amount of their time in documentation and paperwork that's required to meet quality standards that they didn't before.

We're working on systems, automated systems to try to help that out. But I'm much more concerned about that kind of task change than I am with the delivering of trays and water pitchers and so forth.

Senator HEINZ. I understand that. I'm just trying to ascertain whether that's a component of the problem.

Mr. PEPPER. I don't believe it is as much a component as the change of severity, which I think is the greatest——

Senator HEINZ. I understand that. And I think the record is very clear that the severity and the depression is the principal factor. But to the extent that there is a contributing factor that imposes 10 or 15 or 20 percent more demand on a nurse than heretofore is a significant, if not determining——

Mr. PEPPER. I would not deny that there must be some contributing factors, if that's what you're saying.

Senator HEINZ. I'm just really trying to get an idea of the scale of the factor. Is it 5 percent or 10 or——

Mr. PEPPER. I would estimate if the workload has increased 5 percent, it's too much, but I will not say that it is 10 or 15 percent.

Senator HEINZ. So you don't think it's that high?

Mr. PEPPER. I think severity is the worst.

Senator HEINZ. That's not the issue. The issue is—I agree with you, severity is clearly an issue. The question is, is it 5 percent or is it more in the scale of 10 or 15 percent?

Mr. PEPPER. I do not believe anyone has accurately measured this.

Senator HEINZ. It might be worth looking into. The anecdotal testimony on that that we've had seemed quite logical, and logic doesn't always mean truth.

Mr. PEPPER. It may produce it at any rate.

Senator HEINZ. That's right. Let me ask Mary Naylor. Mary, you've basically testified to a series of incentives for people to both enroll and presumably graduate from nursing programs of one kind or another. Our previous panel of witnesses—Patricia Prescott in particular—said, well, supply side of economics is not what is needed here. How do you respond to that?

Ms. NAYLOR. Actually my testimony really spoke to enhancing the work environment.

Senator HEINZ. It did, and I don't mean to ignore that, but you have also——

Ms. NAYLOR. I believe that what is needed is a two-pronged approach to addressing the issue. Without major change in the work environment——

Senator HEINZ. Nothing will work.

Ms. NAYLOR. Nothing will work. Simultaneously, however, we have to begin to reach out to qualified students and to increase the nursing pipeline. We need a pool of qualified nurses capable of working in those environments which are experimenting with new strategies. Supply-and-demand side strategies need to go hand in hand.

Senator HEINZ. But Patricia's point was, if you supply a lot more nurses——

Ms. NAYLOR. I agree.

Senator HEINZ. Nurse entrants, two things can happen, both of them bad. One, that you depress or prevent from rising to competitive levels, starting salaries; and second, that creates a great temptation to substitute new entrants into the nursing profession for retention. So if you don't want to pay more because you can't or whatever the reason may be, you say goodbye to that nurse and quickly grab a new one that is cheap.

Ms. NAYLOR. I agree that we need to undertake major restructing in the work market in order to even hope to recruit and retain quality nurses.

We're in the position we're in now because our work environment was not at all conducive to attract bright men and women. By the same token, if we do not continue our efforts to recruit qualified individuals, hospitals will seek other types of providers to deliver nursing services. So I think that we need to aggressively begin to look at ways in which we can simultaneously develop an environment which will sustain the bright men and women in nursing and hospitals and also maintain a pipeline so that we have that kind of personnel that would be needed to work in those environments. Otherwise, we'll have no profession.

Senator HEINZ. So you feel we need to do both?

Ms. NAYLOR. Absolutely.

Senator HEINZ. Let me ask Dr. Willging, you make the point that the nursing home payments under Medicaid and Medicare are not sufficient to compete with hospitals and nurse wage deficits and so forth. Yet, as I understand it, your own survey shows that 41 percent of nursing homes report no nurse vacancies. Is that correct? And if so, how have those homes avoided the shortage problem?

Dr. WILLGING. Well, the shortage problem does have its peaks and valleys across the country. More critically, I think, the nursing home industry, dependent as it is on Medicaid has its reimbursement peaks and valleys across the country I suspect we have a fairly serious problem—I wish I had the State-to-State data with me—in a State like Arkansas with a rate of $31.51 a day for daily skilled care. A problem less serious in the States such as New York where the Medicaid Program pays on average $92 per day for daily skilled nursing care.

There's also the question that if one is capable and willing and desires trying to track primarily the private pay patients, it's difficult, because 65 percent of all patients in this country in nursing homes are Medicaid patients, there's also less of a problem because one can then through private pay patients bring those rates up.

Senator HEINZ. Let me ask this, would it be possible for you to give us the data on where the nursing homes that do not have nurse shortages are, so that we can correlate them with Medicare and Medicaid reimbursement paid, and probably even more importantly—overall reimbursement. There are those exceptions to the rule with nursing homes that still have a substantial proportion of private pay patients. I think it would be very helpful to understand the issue to see those factors—location, percentage of patient distribution Medicare and Medicaid and private pay relative to and their correlation with shortages. It may be random, it may be correlated, and it may not be possible, but perhaps we could learn something.

Dr. WILLGING. Well, it may be correlated and possible and we still won't understand it, but we'd still try to conduct the survey.

Senator HEINZ. But at least we'll know the depths of our ignorance.

Dr. WILLGING. Correct.

Senator HEINZ. I would appreciate that.

There's been a lot of testimony today about the need to improve the status of the nurses on the job, improve the conditions in which they work. Would you agree with that?

Dr. WILLGING. I think there's no question. I think while it's clear to me that the public policy has a role to play, particularly in the area of wages, salaries, and incentives, we in our industry have a job to do as well. We to some extent have contributed to our problems, particularly in terms of image in the workplace. We have not reached out to the community. We have not as an industry reached out to help the nursing schools. We have not gone out of our way to try to make it clear to those who are contemplating a career choice in nursing that the nursing home can, in fact, be a desirable place to work. So, yes, you are absolutely correct, and there's an area where we have some more to do. We cannot simply shift blame to some other sector of society.

Senator HEINZ. What kinds of retention problems do nursing homes have?

Dr. WILLGING. Well, we have retention problems even more serious than the hospital industry. I believe the data shows that the hospital industry, there is a retention factor of only about 80 percent after a year. It goes down to 70 percent after a year in the nursing home industry. And I suspect it correlated on the same basis as the other issues.

The Department of Health and Human Services recently produced a study which did get into the whole area of retention, and as one would anticipate, the factors are the obvious ones. They relate again to salary, relate again to autonomy, the ability to work as a nurse as opposed to carrying someone else's water and so forth. There are a number of factors. There are three or four basic causal factors that impact not just on recruitment but equally on retention.

Senator HEINZ. Now, you mentioned that you experienced shortages of both LPN's and RN's?

Dr. WILLGING. Correct.

Senator HEINZ. I assume that you feel that we should improve our incentives for people to enter into both the LPN programs and the RN programs?

Dr. WILLGING. We feel we have no choice. Until we can resolve the shortage issue and the reimbursement issue with respect to RN's in nursing homes, if indeed we did not have adequate supply of LPN's as well, the issue would be just as serious or as equally disastrous.

Senator HEINZ. Is there a Federal role in doing something about LPN's?

Dr. WILLGING. I believe there can be a Federal role. I believe that it's not equalizing the same authorizing legislation that one works with in terms of the more traditional nursing programs, but

certainly in terms of vocational education, which is what we're talking about.

And I think there is some societal impact as well, because traditionally LPN's have come out of the economically disadvantaged sectors of society. By bringing that individual initially into the LPN programs, I think we can also work with the schools of nursing to make sure there is a career path through ultimately the 4-year RN program and starting with the 2-year associate degree program. So I think there are a variety of benefits not just related exclusively to the nursing industry.

Senator HEINZ. In Pennsylvania half of the LPN programs in the last, what, 6, 7 years have closed.

Dr. WILLGING. The LPN programs have been cut in half not just in Pennsylvania but across the country. Diploma schools which provided most of our RN's during the course of the past 10 or 15 years are being cut back dramatically. This is simply one aspect of the entire problem. BS programs have also been cut back. Duke University, Boston, have all cut out their 4-year programs.

Senator HEINZ. And the main reason for that is what?

Dr. WILLGING. The main reason for that, I believe, in my simplistic economic approach to things is that as a young lady now looks to making a career choice, and I don't know why one should criticize this, one looks at potential reimbursement as well as rewarding professional responsibilities.

Senator HEINZ. What is the average entering pay for an LPN?

Dr. WILLGING. For an LPN it's around $6 to $7.50, varies again across the country. An RN in the nursing home industry, the average is around $8 to $10 across the country.

Senator HEINZ. And that range is what, $16,000 or $17,000 a year?

Dr. WILLGING. I'm a lobbyist in political science. I have to think hard when it comes to multiplying and dividing. If you're at $7 an hour, it's $14,000 a year.

Senator HEINZ. And the average salary creeps up a bit, I guess?

Dr. WILLGING. Creeps up a bit. We have the same depression, of course, in our nursing home industry as is the case in hospitals.

Senator HEINZ. Going back to the RN issue, if we increase the incentives for people to enter the nursing profession, to go to any of the programs that produce RN's, and neither the hospitals nor the nursing homes make the kinds of improvements that you suggest are needed and the others suggest are needed, what's going to happen?

Dr. WILLGING. What's going to happen is as the panel suggests, we won't solve the problem. We do have both the demand and supply problems, although I do believe that those who argue it's mostly demand and not supply are saying they don't want a solution that might cost money.

Senator HEINZ. Let me ask George McNeal, Dr. McNeal, you've got an interesting problem. You're opening a new VA hospital in March of 1989.

Dr. MCNEAL. That's correct.

Senator HEINZ. How are you going to do the staffing?

Dr. MCNEAL. Well——

Senator HEINZ. We just heard that there's liable to be nothing available.

Dr. MCNEAL. It's going to be a problem. We will probably open it in modules, in 60-bed modules. I'm sure some of the staffing will come from the acute care facility that we have, and the rest we will simply have to compete with others as has been testified.

Senator HEINZ. What about your nursing home? It seems to me that you're in real trouble.

Dr. MCNEAL. Yes, that is the facility that I'm talking about, the 240-bed nursing home. We'll need over 150 nurses. It's a problem, a challenge.

Senator HEINZ. We are running a little over. I just want to kind of summarize, unless there's any additional comments any of you would like to make.

What I think we've learned is that the nursing shortage both in nursing homes and in hospitals is critical. That it has a very serious impact on patient outcome and that impact will, if unaddressed, become more serious and contribute to the total breakdown of the delivery of what we conceive to be quality health care.

Second, as to solution, there are two main components of that solution. The first is that the retention problem is serious and likely to get worse because the trends underlying the retention problem, which is more and more work being imposed on fewer and fewer people with better and better choices to go elsewhere, are not going to go away. They are likely to continue in terms of costs, because the Federal budget deficit is unlikely to, I'm sorry to say, magically go away, and so forth. The trends causing the problem of making retention difficult are unlikely to suddenly get better. Therefore, it is imperative that hospitals and nursing homes understand that they and they alone are a vital part of the solution. Only they can impact the work climate in nursing homes and in hospitals which is a serious part of the problem.

It may very well be that the DRG system is inadequate to take into account the severity of illness, the nursing component, although ProPAC's testimony on the latter point throws that into question.

Finally, it appears to me that simply increasing the supply of nurses through a variety of incentives would in a sense be self-defeating unless the health care industry as a whole addresses the retention problem. It seems to me that simply addressing retention without increasing supply is unrealistic. Not simply because halting the retention drain would not provide enough nurses, but the demands on the health care profession are likely to continue to increase, and the shortages today are very real. As a result, it seems to me that we in Congress would do well to sufficiently increase and at the same time to target existing educational funds to training staff for nursing homes, critical care, emergency room care, and other difficult settings that presently show the greatest shortages of nursing.

Additionally, I would like to see if it would not be possible that older worker employment funds could also be targeted to recruit people to work as health aides in hospitals and nursing home settings.

It seems to me that we have to do more to attract people into nursing programs generally and to target those people in the areas of greatest need. But if we do that and the health care profession as a whole, the managers and hospital administrators and nursing home administrators don't do their part, we will not solve the problem, and we will continue to hear an increasing number of stories of people who died, had heart damage, suffered broken hips and dislocated shoulders and perhaps worse because there just weren't enough well-trained, well-intentioned well-meaning people to go around.

I want to thank all of you at this time for an extremely fine contribution. I thank you for being a part of this and other efforts. And, Paul, you're becoming a very experienced witness in front of this committee.

Mary, you have seen it from both sides.

Perry, I thank you for some extremely able testimony.

And Dr. McNeal, we wish you more than good luck. We want to help you in every way we can, because you have what I might call a 100 percent nursing shortage.

Thank you all very much.

APPENDIX
Item 1

VANISHING NURSES, DIMINISHING CARE
Staff Report by the
Minority Staff of the Senate Special Committee on Aging
Senator John Heinz, Ranking Member
April 6, 1988

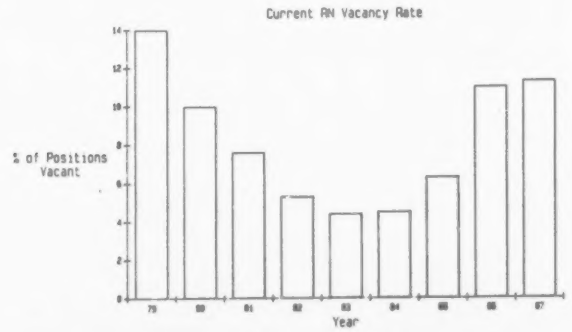
In the last two years, hospitals, nursing homes, and home health agencies have reported increasing difficulty attracting and retaining qualified nurses to fill vacant staff positions. While cyclical nurse shortages have plagued the American health care system since the 1940's, there are indications that this particular nurse shortage may be more serious than previous shortages because of the factors contributing to it.

A unique aspect of the current nurse shortage is that it has triggered intense reactions from nurses themselves, precipitating in several locations strikes and work stoppages. Three recent actions have been particularly noteworthy:

- **USC-County Medical Center Nurses Strike.** On January 26, 3,200 nurses at USC-County Medical Center in Los Angeles staged a walkout protesting low wages, inadequate nurse staffing, and consistent mandatory overtime. One of their demands was that the facility hire 1,000 more nurses, enough to bring the facility to par with legal nurse staffing standards.

- **New York "Sick Outs"** In February of this year, 4,000 nurses in 4 New York City area hospitals (Montfiore Medical Center, Manhattan; Woodhull Medical/Mental Health Center, Brooklyn; Bronx Municipal Hospital Center, Bronx; and Lincoln Medical Center, Bronx) staged "sick outs" protesting the poor quality of care that was being provided in these facilities because of nurse understaffing in all hospital settings.

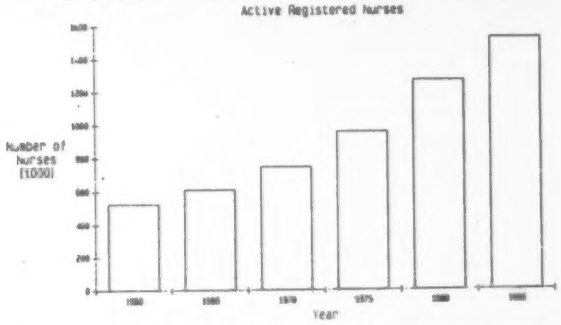
The current nurse shortage may be more serious than previous shortages for several reasons. First, the current nurse shortage is widespread. Data from the American Hospital Association (AHA) and the American Health Care Association (AHCA) survey data point to a growing shortage of nurses in a variety of settings. In hospitals, the average RN vacancy rate was 11.3 percent in 1987, nearly double the 6.3 percent vacancy rate in 1985. Nursing homes find themselves in an even more desperate situation with 57 percent of AHCA facilities reporting vacant RN positions. Thirty-two percent of nursing homes do not even have enough RNs to meet minimum staffing standards.



(source: AHA Report of the Hospital Personnel Survey, 1987)

According to AHA testimony before the Senate Finance Committee on October 30, 1987, "... the current shortage is particularly serious because it cuts across all types of nurses, types of hospitals and regions of the country."

Second, the current nursing shortage exists despite the fact that there are more nurses in the population and a higher ratio of nurses to patients than ever before. In 1985, there were 1,531,000 active registered nurses in the U.S. population, more than 600,000 more than there were a decade ago. At the same time, there were more nurses per patient than ever before. Over the last decade, the nurse to patient ratio has nearly doubled from 50 nurses to 91 nurses per 100 patients.



(source: U.S. Bureau of the Census 1988 Statistical Abstracts of the United States)

Third, although the current shortage exists in the midst of a maximum supply, there are new signs that the future supply of nurses has begun to decline. While the 1985 graduating nursing class was the largest in history, fewer and fewer students are expected to enter nursing schools in the coming years.

WHY IS THERE A NURSE SHORTAGE NOW?

Rapid changes in the way medical care is provided have contributed to a dramatic increase in the demand for nursing care in traditional settings, an increase in the level of nursing skills required in these settings, and a proliferation of competing uses for trained nurses. At the same time, improvements in working conditions, pay, and professional status have failed to keep pace. The result has been a shortage in highly-skilled nurses, problems in the allocation of existing nurses, and now a beginning exodus of nurses from the profession that are creating the visible signs of the nurse shortage.

Experts offer several explanations for the current nurse shortage:

1) **Increasing Hospital Demand:** The demand for specialty nurses in hospitals has grown in recent years to meet the needs of a sicker patient population. This change in patient population is a result of both advances in medical technology and changes in hospital reimbursement.

- Advances in medical technology have kept patients alive longer with more severe illnesses requiring a more intensive level of nursing care. They have also increased the level of skill required to monitor and manage patients.

- Medicare's Prospective Payment System (PPS) has encouraged shorter hospital stays. Nursing services previously delivered in a longer time span must now be condensed into a shorter stay. Hospitals have begun to fully staff RNs around the clock to provide nursing services before the patient is discharged.

- Shorter hospital stays associated with PPS have led to much of the less-intensive care being provided in out-patient and community settings. As a result, the remaining hospital population has a higher concentration of the sickest patients. AHA's survey data shows that 81 percent of hospitals reported that their patient populations were more acutely ill in 1986 than in 1985.

- Hospitals have sought, in the wake of PPS, to reduce costs by reducing ancillary nursing personnel -- expanding the range of tasks that have to be performed by the registered nurses on staff.

Nursing shortages have been most severe in the hospital units that deal with the most acutely ill. AHA's 1987 hospital survey shows that:

- 90 percent of medical surgical units report RN vacancies which require 60 or more days to fill;
- 80 percent of intensive care and critical care units report RN vacancies which require 60 to 90 days to fill;
- 70 percent of operating rooms and emergency rooms report RN vacancies which require 60 days to fill.

2) Increasing Demand in Non-Hospital Settings:

Non-hospital nursing settings have expanded in recent years - particularly as a result of the shift of patients out of hospitals in response to Medicare's PPS. This increase in patient load has created a growing demand for nurses generally, and more-skilled nurses specifically in nursing homes and home health agencies. For example, the home health care market alone has grown from 1,275 to 6,005 providers between 1966 and 1986. This growth in non-hospital demand has increased the demand for registered nurses overall, resulting in more competition between hospital and non-hospital settings for the existing supply of nurses.

To date, there is no evidence that the allocation of registered nurses has been measurably affected by the shift in care to non-hospital settings. The percentage of RNs working in hospitals (68 percent) has remained fairly constant, largely because of the increasing intensity of care and higher nurse-patient ratios in hospital settings, as shown in 1977 and 1984 surveys conducted by the Public Health Service, Division of Nursing:

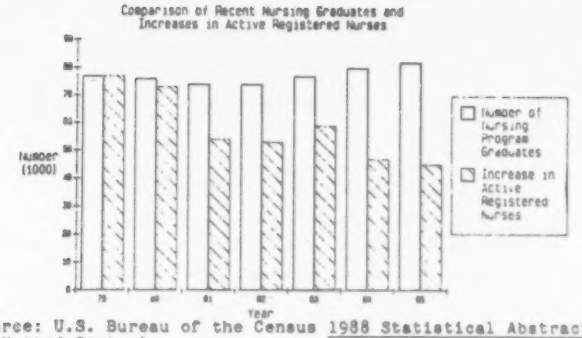
- 68.1 percent of practicing RNs are working in hospitals, compared to 62.7 percent in 1977;
- 7.7 percent are in nursing homes and extended care facilities, compared to 8.3 percent in 1977;
- 6.8 percent are in community and public health, compared to 7.3 percent in 1977;
- the remainder (10.8 percent) are working in nursing education, student health services, private duty nursing or self employed, compared to 13.7 percent in 1977.

3) Demand for Nurses in Other Health-Related Settings is Increasing:

The substantial growth in health-related activities has opened up competitive job opportunities that are now attracting nurses out of traditional medical settings - reducing the pool of nurses willing to work in hospitals and nursing homes. A host of new case-management, utilization review, and quality assurance activities in recent years has greatly expanded the job opportunities for highly-trained health professionals outside of the traditional medical settings. These new jobs with health insurance plans, peer review organizations, and private agencies frequently afford nurses the opportunity to work for higher pay, with more manageable hours, and less-stressful working conditions than they can find in hospitals and nursing homes. The result is a group of active registered nurses who are not willing to fill vacancies in the more specialized and intensive sectors of the health care system.

4) Attrition of Nurses from the Profession

Although 80 percent of registered nurses are actively participating in the workforce, a comparison of recent nursing graduates to increases in active registered nurses suggests that nurses have begun to leave the field in large numbers. In 1979, the number of nurses added to the profession was roughly equal to the number of nursing graduates - indicating that most nurses already in the profession were staying. By 1985, an infusion of 82,000 new nurse graduates increased the profession by only 45,000, indicating a loss of 37,000 nurses in a single year.


Comparison of Recent Nursing Graduates and Increases in Active Registered Nurses
Number (1000)
Year
Number of Nursing Program Graduates
Increase in Active Registered Nurses

(source: U.S. Bureau of the Census 1988 Statistical Abstracts of the United States)

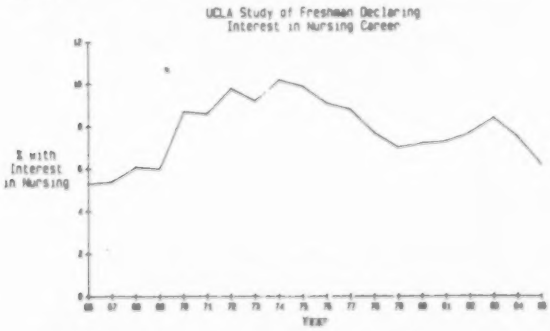
Nurses contend that the substantial attrition from the nursing profession is result of the combination of low-pay, difficult working conditions, and lack of professional esteem. Cyclical shortages and the traditional supply side response have contributed to the wage and career-ladder compression seen in the field of nursing. Emphasis on recruitment by hospitals offering entry bonuses with no comensurate bonuses for existing staff can actually contribute to the problem of high turnover rates. At a national average starting salary of $21,000/year, nurses begin at a pay level comparable to many other professionals. However, within 7 years the pay scale peaks at roughly $7,000 more than starting salary.

In addition, the expansion of non-traditional career opportunities for women has helped to encourage women to leave traditional careers like nursing for a more-lucrative second career.

5) Decline in the Flow of New Nurses:

The annual flow of new entrants into nursing has reached a peak in recent years, and is now showing signs of a long-term decline. One factor causing this decline is that the population in the 18 to 24 year old age cohort that accounts for most new nursing students is shrinking. By 1990, the size of that age cohort will have declined by 14 percent from 1980 levels.

Another factor limiting new entrants is that nursing has become a less popular career choice among those entering college today. For example, a 20 year UCLA study of the career intentions of first time college freshmen has revealed a significant drop in interest of freshman students in the field of nursing.



(source: UCLA, The American Freshman: 20 Year Trends, 1966-85)

Nursing education today occurs at a wide variety of levels leading to a number of different certifications:

- Licensed practical nurses and geriatric practical nurses have an average of 18 months of clincial, largely on-site training.

- Registered nurses come through a variety of education routes: (Statistics from the National League for Nursing)

  - 2-3 year Associate Degree -- these programs are largely based in community colleges. Emphasis on basic science courses and clinical training. Graduates currently comprise 25.1 percent of the nurse force.

  - 3 year hospital-based Diploma Degree -- education is basic sciences and more emphasis on clinical training. Graduates currently comprise 41.8 percent of the nurse force.

  - 4-5 year college or university-based Baccalaureate Degree -- emphasis is on the theoretical as well as some clinical background as well as liberal arts coursework. Graduates currently comprise 23.9 percent of the nurse force.

  Graduates with any of these degrees are eligible to take the nurse registry examination. Upon passing that, they are conferred with the title "registered nurse," despite the differences in their educational background. Frequently, the hospital starting salary is the same regardless of education.

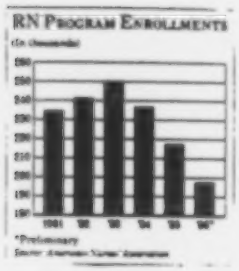
- Certified nurse practioners generally have master's or doctorate degrees in advanced nursing care and are certified to do basic patient diagnosis, and some prescribing of medications. This field is also broken into specialities, such as geriatric nurse practioner, nurse midwives, certified nurse anesthetist, etc.

One final factor limiting the pool of new entrants into nursing is the elimination of lower levels of training and lower-skilled nursing jobs that once permitted minority and disadvantaged populations to enter the nursing profession. Traditionally, the licensed practical nursing program (LPN) has been the avenue through which those unable to afford to attend college or graduate schools could enter the nursing field. Minorities have been much more likely to work as practical nurses than registered nurses. In 1984, 16 percent of all practical nurse students were Black, compared to only 4 percent of all registered nurses.

Efforts to emphasize higher levels of training in nursing nave led to an erosion in funding for LPN training and to the closing of a number of programs across the country. In Pennsylvania, State reimbursement for LPN training in secondary schools and community colleges has dropped substantially in recent years. In the last seven years, the State has reduced its reimbursement to LPN student from 98 percent to only 38 percent of their tuition. In the last 2 years alone, half of the remaining 98 LPN programs in Pennsylvania have been closed.

The result of the closing of LPN programs is to divert minority and disadvantaged students away from the nursing profession. Minorities currently are unlikely to enter college and graduate nursing programs, and are frequently not encouraged by guidance counselors to pursue a career in nursing.

Overall, there has already been a noticable decline in nursing school enrollments.



WHAT IS THE EFFECT OF THE NURSE SHORTAGE?

When hospitals experience difficulty filling vacancies in their nursing staffs, they often respond by taking actions that make working conditions even worse for the remaining nurses, and may, in fact, contribute to attrition from hospital settings and from the nursing profession.

- **Mandatory Overtime.** When faced with inadequate staffing for a shift, some hospitals will first ask if any of the nurses on the current shift are willing to work overtime to cover the next shift. If there are no volunteers, nurses will be selected and required to work the next shift. In instances, such as those in New York City and Los Angeles, these practices continued over a period of time have resulted in provoking organized demonstrations against the practice or strikes.

- **Temporary Agency Nurses.** Many, hospitals will fill voids in their nursing staffs with temporary agency nurses. When this practice is used on an on-going basis, may reduce the quality of patient care as well as affect the morale of the remaining staff nurses.

The lack of staffing continuity from using temporary nurses is a problem for patient care. Temporary nurses, who lack a familiarity with the patients, may fail to notice small but significant changes in patient conditions. In addition, temporary nurses are a drain on the on the full time nursing staff because they must learn the layout, procedures, and patient histories of a new facility before they can begin to care for patients independently.

The use of temporary nurses may also be demoralizing to the staff nurses. Temporary nurses may get paid more and work more manageable hours than the fulltime staff. Staff nurses, who do the same work for lower wages and on the unpopular shifts, may justifiably feel mistreated. Many staff nurses quickly catch on to the advantages of working for an agency, leave facility employment to work for agencies, and in some cases, turn around and return to their original workplace at higher pay and with better hours. This situation is particularly demoralizing for the remaining staff nurses.

- **Operating Understaffed.** With the combined impact of increased medical technology and shortened inpatient hospital stays, patients are sicker and require a higher level of nursing skill and care. If a unit operates without enough nurses to adequately care for the patients, especially in the intensive care, critical care and emergency units, it runs the considerable risk of not having enough staff to attend to multiple emergencies -- not an uncommon occurance in these units. Furthermore, with increased responsibilities for a variety of hospital functions being placed on nurses, there is little time to do more than provide cursory care.

Nurses who are forced to work when the staffing levels are below determined safe standards are, as explained, at a much higher risk for errors which could result in suit being filed against the insitution and charges against the nurse. In response to this, many unions representing nurses have instituted programs for nurses to notify their supervisors and sometimes hospital administrations that the staffing conditions are unsafe.

Compounding the increased patient care demands on nurses is the move by a significant percentage of hospitals to decrease their ancillary personnel staffs. This means that RNs are also filling the staff gaps for housekeeping, nurses aids, and orderlies.

- **Rotating less experienced or undertrained nurses into specialty care units.** Filling shift vacancies by rotating other non-specialized nurses seriously compromises the quality of care received by patients in those wings. Specialty units, such as critical care, neonatal, and cardiac care units, typically are for patients with conditions that require specialized knowledge of treatments and demand continual monitoring. A non-specialized nurse could provide these patients with cursory care, but will not be well-enough trained to spot or manage complications which frequently arise among the patients on these wings. In addition, inexperienced or undertrained nurses require on-going supervision from the veteran nurses, increasing the workload for veteran nurses.

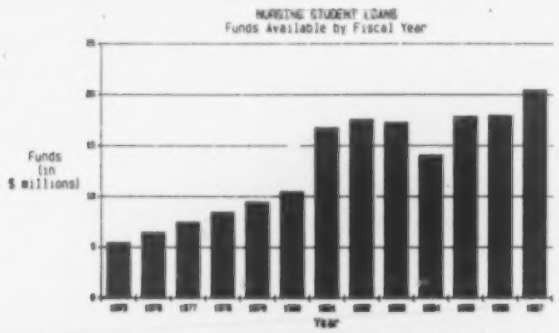
- **Rushing patients through or past specialized units.** In order to keep the nurse/patient ratio within acceptable limits, hospitals may move patients through the understaffed high skilled nursing units and onto the regular medical floors as quickly as possible, or just skip these units altogether. In hospitals which employ these practices, unspecialized nurses on the medical floors are dealing with higher patient acuity levels than they are trained to handle.

- **Closing specialized beds.** As a last resort, a hospital will close specialized beds and sometimes entire units. Most commonly, this occurs in critical care units. When it happens, elective surgeries will be post-poned, and those patients who cannot be delayed will be transferred or detained in other monitored or specialized units, placing an increased burden on the nurses in the remaining units. In January of this year, none of the 11 hospitals in Louisville, Kentucky could accept critically ill patients because every hospital had closed intensive care unit beds for lack of enough nurses to staff them.

WHAT IS THE FEDERAL GOVERNMENT'S ROLE?

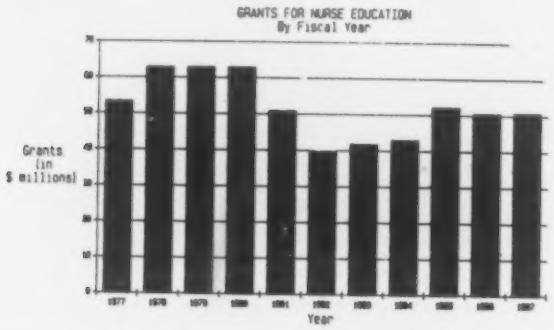
Since World War II and the implementation of the Civilian Nurse Corps, the Federal government has participated in recruiting new nursing students into the field by offering educational benefits. It is now thought by many that this approach, while easing the immediate strain, actually has helped to exacerbate the problem in the long run.

The primary method the Federal government uses to recruit new nurses into the field is by offering special loans for nursing students. These are revolving funds that are made available to nursing students at a reduced interest rate. The money that is repaid is then returned to the fund and made available to other nursing students. Over the last decade, the amount available annually for nursing student loans has been increased twice. In 1987, the U.S. Health Resources and Services Administration (HRSA) made $20.5 million in new loans available for nursing students.



(source: Department of Health and Human Services) and U.S. Bureau of the Census 1988 Statistical Abstract of the United States)

The Federal government also helps to subsidize graduate nurse education in the form of grants to both schools and students. These grants fund nurse traineeships and fellowships, advanced nurse training, nurse practitioner training, general scholarships and NEOG's, and special projects. The amount of direct grant money has declined over the last decade. In 1987, HRSA made $50.8 million in nurse education grants.



(source: Department of Health and Human Services)

The Medicare system also provides for increased monies for teaching hospitals which includes approved hospital-based RN education programs. This is calculated by reimbursing reasonable costs for Medicare's share of the direct educational expenses and allocating overhead based on Medicare's percentage of the hospital's inpatient activity.

Medicare and Medicaid reimbursement are frequently cited as causes for low nurses wages. It is true that calculation of nursing services into the DRG system is complex and may have inadequacies, particularly for high nursing intense categories such as burns. However, the hospital update factor has been designed to accurately reflect local labor costs, including nursing. Furthermore, the argument can be made that cyclical shortages existed before the implementation of the Prospective Payment System, when Medicare was paid by fee for service.

The traditional government response to nurse shortages has been to increase the amount of money available for student loans. Some experts contend that this supply side approach to the problem has been counterproductive. Frequently, additional Federal money has begun to produce new nurses at the end of a cyclical shortage, creating short-term surpluses of personnel. Increasing the supply of RNs in this context may have further depressed wages, exacerbating the volatility of the nurse labor market.

POSSIBLE RESPONSES:

Options for a Federal response could include:

- Targeting post-secondary nurse education funds for non-typical nursing students such as men and minorities to offset the decline of licensed practical nursing which has served as an avenue into registered nursing for low-income and minority students.

- Target training funds and providing loan forgiveness for RNs who will agree to practice in the most difficult and least desirable specialties and settings.

- Target portions of existing Federal employment funds (such as Community Services Employment for Older Americans funds) to subsidize ancillary health care personnel to be located in difficult settings and improve the efficient utilization of existing RN's.

- Require that HHS adopt standards for hospital-based specialty nurse training, and require that hospitals comply with the standards as a condition for participation in Medicare.

- Establish separate accounting in Medicare reimbursement for nursing services.

Equally important are private and non-profit efforts which should focus on stabilizing the field of nursing by not only addressing the challenge of recruiting new nurses into the field, but also retaining the ones we already have. Retention incentives will also serve to make the field of nursing more appealing to both traditional and non-traditional (older students and those seeking to change careers) students. These incentives include things like flexible benefits packages (such as options for day care, pensions and health benefits), flexible scheduling with bonus pay for unpopular shifts, career ladders, and "decompressed" pay scales.

Item 2

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

STATEMENT FOR THE RECORD

FOR THE

SENATE SPECIAL COMMITTEE ON AGING

APRIL 6, 1988

BY THE

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

The Prospective Payment Assessment Commission (ProPAC) is pleased to provide this background statement for the April 6, 1988 hearing of the Senate Special Aging Committee on the nursing shortage. This statement addresses ProPAC's activities on the relationship between nursing and the Medicare prospective payment system (PPS).

ProPAC Background

The Commission was established by Congress at the same time as PPS. ProPAC's mandate is to monitor the implementation and the impact of the Medicare hospital payment system, and to make recommendations for necessary changes. This mandate is fulfilled primarily through a series of reports to the Secretary of Health and Human Services and the Congress.

ProPAC's annual March report to the Secretary provides detailed recommendations for changes needed to update and revise PPS in the upcoming fiscal year. Our June annual report to the Congress describes the impact of PPS on the American health care system. Our November annual report to the Congress comments on the Secretary's regulatory actions under PPS. Periodically, ProPAC also issues other technical reports on specific subjects.

Since its inception, ProPAC has addressed a series of issues related to nursing. The Commission has given priority to addressing appropriate nursing issues. Several staff members and

Commissioners are nurses. While it is not the Commission's role or responsibility to address directly the subject of the Committee's hearing today, we hope that our statement will assist in bringing more information to bear on this important subject.

ProPAC Analysis of Nursing Issues

The Commission examines nursing from several perspectives. One of our primary concerns is the appropriateness of payments under the prospective payment system. Since nursing is a critical component of hospital care, it is important that the payments appropriately cover nursing costs.

ProPAC has two major responsibilities related to DRG payment policy. The first relates to recommending payment updates each year. The second relates to modifications that are needed in the diagnosis-related groups (DRGs) used as the basis of PPS payments.

Hospital Market Basket

One of the basic components in its annual payment update is a measurement of the change in the cost of items hospitals purchase to provide care, called the hospital market basket. Wages and salaries represent the largest single component of the market basket, accounting for 56 percent of hospital costs. A large percentage of hospital wages is for nurses. The wage component of the market basket does not measure changes in nursing wages directly, however. Changes in nursing wages and other professional and technical workers wages are measured by a blend of overall hospital and economy wide wage measures. The Commission, in its April 1, 1985 Report to the Secretary, recommended that this blend of internal and external wage measures be used to evaluate changes in hospital wages in the market basket.

The Commission has been concerned that the wage and salary component of the market basket be carefully analyzed and monitored to assure that changes in nursing wages are appropriately reflected in the market basket. Previous analysis by the Commission concluded that the market basket is basically sound. Several past recommendations for change have been implemented, and ProPAC believes that the market basket is an

appropriate measure of hospital input prices, including nursing and other wages.

The Commission is concerned, however, about the sensitivity of the market basket to large changes in nursing wages. It is the Commission's policy to correct in the subsequent year for errors in the past year's market basket forecast. We will continue to carefully monitor this important area, and will undertake additional review or recommend corrections if necessary.

Nursing Costs and the DRG Weight

The DRG classification system that underlies the prospective payment system classifies every Medicare patient, based upon diagnosis. Payments are based on the relative weights established for each DRG. One of the earliest and most important questions addressed by the Commission was the extent to which the DRG weights accurately reflect variations in nursing costs.

Because of limitations in the data used to calculate the weights, average daily nursing costs are assumed to be constant across the DRGs. This assumption was said to be contradicted by evidence of variation in nursing requirements or "intensity" across DRGs. Over the past three years, ProPAC initiated a series of activities to study this question. This included intramural and extramural research, careful review of studies sponsored by other organizations, and the convening of a technical panel to review all of the accumulated evidence.

All of this activity resulted in a conclusion by the Commission that adjusting the DRG weights to reflect variation in nursing intensity would have minimal effect on DRG-specific payments and an even smaller effect on aggregate hospital payments. Thus, the Commission decided against initiating a major effort to develop nursing intensity adjustments to the DRG weights. The Commission would be pleased to provide detailed information about the research undertaken and the conclusions of the technical panel to anyone who wishes to contact us.

Other PPS Monitoring

ProPAC monitors the more general impact of PPS on the U.S. health care system. We find, however, that PPS is not the only major new system to which hospitals and other providers must adjust. Many payors have instituted new capitated or managed care systems, bringing much greater pressure to bear on providers. These pressures, along with more competition, have resulted in new management initiatives and a vastly changed health care environment. Among other areas of importance, ProPAC therefore tries to keep abreast of changes in the management and delivery of care in hospitals and other settings.

The Commission collects data on hospital employment and staffing, including information about nursing. Our monitoring has shown a number of interesting trends in nurse staffing. For example, according to the AHA, nurse vacancy rates doubled between 1985 and 1986 even though hospitals employed a record number of RNs. Moreover, between 1983 and 1986, the number of RNs employed in short stay hospitals per 100 inpatients increased by about 20 percent.

Hospitals also appear to be increasing their nursing skill mix by replacing other nursing personnel with RNs. This is illustrated by the fact that between 1983 and 1986 the number of RNs employed in hospitals increased by about 35,000 while the number of other nursing personnel decreased by about 125,000. Increases in nursing wages also appear to be starting to accelerate. Interest in nursing as a career choice, however, is declining.

The Commission believes that this type of data should be reviewed when considering nursing issues. We will be presenting our findings regarding the impact of PPS on the American health care system in a report to Congress in June. This report will contain information on a wide array of topics related to PPS, hospitals, and patient care.

We will continue to monitor available data, and will be developing some additional data ourselves in the context of the special research projects we undertake. One of our major research projects in the coming year will study hospital costs

determinants. In an effort to identify the components of cost variation, this study will examine staffing variations, including nursing.

The Commission is also extremely pleased that the Secretary of Health and Human Services has appointed a special advisory Commission to review the nursing shortage and provide further information and action steps. The Commission is chaired by a ProPAC Commissioner, Dr. Carolyne Davis, who has provided leadership on these issues for us. We believe that Dr. Davis' Commission provides the best current forum for discussion and consideration of this issue, and we have pledged our assistance and support to the Commission.

Summary and Conclusion

ProPAC will continue to devote staff resources to the study of nursing issues as they relate to our responsibilities. We look forward to future research and data which will assist in further refining nursing issues, and we will reassess our priorities as new issues emerge. 'e appreciate this opportunity to explain our responsibilities and activities in this area, and will be pleased to assist the Committee in its work in the future.

Item 3

TESTIMONY DELIVERED TO
SENATE COMMITTEE ON AGING
HEARINGS, PHILADELPHIA, PA
APRIL 6, 1988

Nursing shortages are a cyclic and chronic problem. Data suggest the current shortage is much the same as that in the early 80's except for one critical difference, falling nursing school enrollments. Enrollments have been decreasing since 1983-1984, and these declines (5.3% in 1984; 8.1% in 1985; 11.1% in 1987) are expected to accelerate in the foreseeable future. (Rosenfeld, 1987). Falling enrollments and declining ability levels of those entering nursing indicate there will be substantially fewer nurses and they will have less, rather than more, ability than do those in the existing pool (Green, 1987). In the present situation, we are moving toward a dynamic labor market shortage, where the falling enrollments, if they continue, will produce an imbalance in supply and demand.

There are two types of shortage -equilibrium and dynamic - and nursing has experienced both. Equilibrium shortages, such as we experienced in 1980, result when nurse labor markets are not fully competitive; that is they are oligopsonistic. In oligopsonistic markets a few employers, in this case hospitals, dominate the market and wages do not freely rise to balance supply and demand. Employers often want a greater supply than prevailing wages will purchase. (Prescott, 1987).

Although economic theory suggests different responses toward different types of shortage, the federal posture toward nursing shortages has been the same regardless of whether the shortage was of the dynamic or equilibrium type. Efforts to address the problem have been through money to subsidize nursing education with the intent of increasing the supply of nurses entering the labor market.

While nursing education is in need of federal support to increase the proportion of basic practitioners prepared at the Baccalaureate level and increase the percentage of nurses with graduate education, subsidizing basic nursing education has not solved shortage problems in the past. In fact, when the shortage is primarily of an equilibrium type with artificially constricted salary levels, a focus on increasing the supply may

actually make the problem worse by further suppressing wages which in a properly functioning market would rise to attract new recruits to the occupation.

To correct equilibrium shortages, wages must be allowed to rise freely to balance supply and demand. To correct dynamic shortages, such as the one that may be developing as a result of falling enrollments, wages also must rise so that nursing is an attractive occupational choice relative to other options. With the declining pool of eighteen year olds and the ever increasing number of attractive career options open to young people of today in business, computer technology, law and medicine, the economic and psychic rewards of nursing will have to increase dramatically if we are to have an adequate supply of nurses prepared to function in the technologically complex health care system.

Federal policies which encourage hospitals, as the dominant employers of 70% of the Registered Nurses, to increase the economic and psychic rewards for nurses are needed. Rather than address the shortage primarily through the educational system, policies directly influencing the hospital labor market are needed. Given concerns for cost containment, hospitals must be encouraged to internally reallocate resources. At the present, many hospitals continue to lump nursing costs together with other costs in a room and board rate, and consequently they have no clear understanding of how much nursing even costs. Identifying nursing costs as distinct from the room and board cost of hospitals is a needed step so that hospitals can institute variable billing for nursing services, and payors can identify the nursing care component in reimbursable services. HCFA should be encouraged to require hospitals to collect and report data on nursing intensity and hours of nursing care delivered so that a national data base to establish nursing care costs can be developed. Identifying the true costs of nursing should lead to more efficient use of nurses in hospitals.

Encouraging hospitals to develop differentiated wage structures which reward nurses based on education and experience, and staffing patterns which use and pay nurses based on their level of practice, would address both the economic and psychic rewards for nursing. Major role

restructuring of nursing within hospitals, with economic incentives attached to that restructuring, is badly needed. Today the differential between a beginning and an experienced nurse remains very thin, with staff nurses in practice 5 years or less averaging approximately $22,000 per year and nurses with 6 to 10 years experience averaging $25,000 and gaining little thereafter.

Partial funding for these changes can be found by making indirect costs associated with nursing educational programs eligible for Medicare Passthrough support. At this time indirect costs are allowed for medical but not nursing education (AACN, 1988; Petrie, 1981). While the total amount of Medicare Passthrough support for nursing education is unknown, it is thought to be approximately 200-300 million dollars. According to the Congressional Budget Office, in fiscal 1987 medical education received 1.1 billion in direct and indirect subsidy. Given that the Nation has an established physician surplus and that nursing is moving toward a serious dynamic shortage, a more equitable distribution of passthrough monies in support of nursing is warranted. Such monies should be used to support graduate nursing education and to encourage a differentiated wage structure tied to education and experience and designed to increase hospital retention of nurses. Supporting nursing at the level of the hospital as well as through subsidy of nursing education will help correct problems in the delivery system which contribute to nursing shortages. In particular use of Medicare Passthrough funds to encourage a differentiated wage structure will help assure that nurses with ten years of experience earn more than the new graduate.

Future trends point to an aging population with increasingly complex health care needs. The technology of care and its specialization are also increasing. Today's general hospitals are like the intensive care areas of 20 years ago, and the acuity level of patients in nursing homes now approximates that previously seen in hospitals. Table 1 indicates that the number of intensive care days is on the increase while the days of routine care decline.

To competently meet future patient needs, nurses require more and better focused education. In many acute care settings nurses' aides and licensed practical nurses are not utilized because they do not have the skills needed. Currently many LPN's are being encouraged to seek the additional education needed to obtain Registered Nurse licensure. Federal support for such programs is needed until existing practitioners are upgraded. However, retraining is more costly and less efficient than is initial training at entry level and federal support, especially for minorities, to enter nursing at the Registered Nurse level is needed. Currently approximately 8% of Registered Nurses are minorities (predominantly black) and 18% of LPN's are from minority groups. (ANA, 1985). Federal support for minorities to enter nursing as Registered Nurses will help prevent them from being sidelined into non promotable positions at the bottom of wage scales.

In summary, the existing pool of nurses is on the decline. The average age of licensed Registered Nurses is 39 years and within the next 20 years a large number of these nurses can be expected to retire. At this time the number of new recruits entering nursing is decreasing in number and ability. Unless substantial changes with long range impact on wages and working conditions are made to make nursing attractive in comparison with other occupational choices, there will be fewer nurses to care for an aging population with increasingly complex health care needs.

I'd like to end with a personal observation. For years hospitals have treated nurses much like disposable supplies rather than a valued resource to be developed and nutured. Nurses have been underpaid, overworked and their contribution to patient care devalued. Hospitals have used up nurses, replacing "burned out" staff with bright new recruits each year. Nurses have tolerated these conditions in large part because they had few alternative options. That is no longer true, and to meaningfully address the roots of the shortage hospitals have to decide that it is time they stop abusing nursing.

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TABLE 1

Adult Medical-Surgical Services
Routine and Special Care Days
All Connecticut General Hospitals

Fiscal Year	Routine Days	% Diff. Previous Year	Special Care Days	% Diff. Previous Year
1982[1]	2,477,557	+ .093	1,73324	+3.93
1983[2,3]	2,431,631	- .185	1,78330	+2.89
1984[4]	2,273,474	-6.150	1,83637	+2.98
1985	2,067,421	-9,060	1,83892	+0.14
1986	1,880,413	-9.050	1,83544	-0.18
TOTAL		23.1%		8.4%

1. TEFRA passed September 1982
2. Schweiker Report 1982
3. Prospective Payment passed 1983
4. All but one of Connecticut Hospitals on Prospective Payment 1984

Source - Connecticut Hospital Association
Courtesy - John Thompson
Yale University

Item 4

US SENATE SPECIAL COMMITTEE ON AGING
HEARING ON "VANISHING NURSES: DIMINISHING CARE"
APRIL 6, 1988

NURSES DESCRIBE HOSPITAL CONDITIONS

Five nurses, from different areas of the nursing field, speak out about their experiences as nurses in understaffed hospitals.

Nurse I: Linda Desmond, working in a hospital in Hazelton, Pennsylvania arrived at work for the 3-11 shift and found that she and two nurses aides, one of whom was pregnant, were the only ones there to care for 8 critical care patients, 3 of whom were on respirators. There were several close calls!!

Nurse II: Charlotte Lacey, 23 years of experience, working in med/surgery ward at Brownsville hospital in Brownsville, Pennsylvania, reports that one night she had to work a double shift, and take care of 30 patients all with IVs. The only staff there to help her were 2 RNs, 2 LPNs and 1 nurse aide. She commented, "the nurses are getting frustrated because they can't do everything they know they should be doing."

Nurse III: Nursing veteran of a teaching hospital in Pennsylvania, made an insightful comment about the nursing situation, "we're getting very high tech, but there are not enough fingers to push the buttons."

Nurse IV: Maria Talamo, eleven years experience as a coronary care nurse working in critical settings, currently working for a temporary agency observed that in the intensive care unit of five hospitals patients were being staffed two patients per nurse regardless of acuity of patients. "With this sort of staffing," Talamo said, "nurses are unable to deliver intensive rehabilitation which would speed recovery and reduce complications."

Nurse V: Cheryl Griffin has been in nursing for 20 years. Worked part time in a surgery unit of a small urban Philadelphia hospital, encountered situations where units were staffed with 10-13 patients per RN and nurse aide. "Nurses aide can not change dressings, or take orthopedic patients in and out of bed," said Griffin, "therefore, the staff nurse who has already has 10-13 patients to care for must think supervise and document everything they do without enough time to do it all and care for the patients."

Item 5

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
519 C STREET, N.E., STANTON PARK
WASHINGTON, D.C. 20002
(202) 547-7424

MARGARET J. CUSHMAN
CHAIRMAN OF THE BOARD
VAL J. HALAMANDARIS
PRESIDENT

HONORABLE FRANK E. MOSS
SENIOR COUNSEL

TM

STATEMENT OF

THE NATIONAL ASSOCIATION FOR HOME CARE

SUBMITTED TO THE

SENATE SPECIAL COMMITTEE ON AGING

SENATOR JOHN HEINZ, RANKING MEMBER

APRIL 6, 1988

SENATOR HEINZ AND MEMBERS OF THE COMMITTEE:

THE NATIONAL ASSOCIATION FOR HOME CARE (NAHC) IS THE NATION'S LARGEST PROFESSIONAL ORGANIZATION REPRESENTING THE INTERESTS OF HOME HEALTH AGENCIES, HOMEMAKER-HOME HEALTH AIDE ORGANIZATIONS AND HOSPICES WITH APPROXIMATELY 5,000 MEMBER ORGANIZATIONS. WE WISH TO COMMEND YOU FOR HOLDING THIS HEARING TO FOCUS ON THE NURSING SHORTAGE. THIS IS AN ISSUE OF CRUCIAL IMPORTANCE TO HOME CARE PROVIDERS AND THE MEDICARE BENEFICIARIES THEY SERVE.

HOME CARE SHORTAGE OVERVIEW

THERE IS AN ACUTE HOME CARE SHORTAGE OVERVIEW PERSONNEL SHORTAGE IN HOME CARE TODAY. THE SHORTAGE INCLUDES REGISTERED NURSES, PARAPROFESSIONAL WORKERS AND THERAPISTS. THE SHORTAGE IS REACHING CRISIS PROPORTIONS AND IS SERIOUSLY THREATENING THE ABILITY OF HOME CARE AGENCIES TO DELIVER QUALITY SERVICES. THIS IS A NATIONAL SHORTAGE AND NOT CONFINED TO URBAN OR RURAL COMMUNITIES.

THROUGHOUT THE NATION HOME CARE AGENCIES ARE EXAMINING THEIR COMMITMENTS TO THE ELDERLY AND LONG TERM CARE POPULATIONS AND ARE BEING FORCED TO CUT BACK ON SERVICES. THESE AGENCIES SIMPLY DO NOT HAVE THE NECESSARY PERSONNEL AND/OR THE FINANCING TO MEET THEIR COMMITMENTS. NAHC IS CURRENTLY CONDUCTING A SURVEY TO DETERMINE THE NATURE AND EXTENT OF THE SHORTAGE AND WILL SHARE THE FINDINGS WITH THE COMMISSION UPON COMPLETION. HOWEVER, EARLY RESULTS DO INDICATE A CRITICAL SHORTAGE OF NURSING PERSONNEL THROUGHOUT THE UNITED STATES.

ALTHOUGH THE SHORTAGES IN HOME CARE AFFECT SEVERAL CATEGORIES OF PERSONNEL, FOR THE PURPOSES OF THIS HEARING WE WILL FOCUS ON THE SHORTAGE OF NURSING PERSONNEL WHICH INCLUDES REGISTERED NURSES, LICENSED PRACTICAL OR LICENSED VOCATIONAL NURSES AND HOMEMAKER-HOME HEALTH AIDES. THE SHORTAGE PROBLEMS OF THESE CATEGORIES ARE INTERRELATED IN TERMS OF CAUSES AND SOLUTIONS.

THE REGISTERED NURSE

FOR HOME CARE PROVIDERS, A SHORTAGE OF REGISTERED NURSES, AT A TIME WHEN PATIENT CASE LOAD AND ACUITY LEVELS ARE INCREASING, ALONG WITH ADDITIONAL PRESSURES FOR AND EMPHASIS ON QUALITY ASSURANCE, IS DISASTROUS. HOME CARE PROVIDERS ARE NOW COMPETING WITH OTHER EMPLOYERS FOR A DWINDLING NUMBER OF NURSES TO FILL THEIR STAFFING NEEDS. DURING PREVIOUS PERIODS OF NURSING SHORTAGE, COMMUNITY AND HOME HEALTH SERVICES ACTUALLY BENEFITTED FROM THE FLIGHT OF BACCALAUREATE NURSES -- IN PARTICULAR, FROM THE HOSPITAL TO THE COMMUNITY SETTING. IT NOW APPEARS THAT HOME CARE AGENCIES ARE EXPERIENCING SOME OF THE SAME NURSE RECRUITMENT AND RETENTION PROBLEMS THAT HAVE PREVIOUSLY PLAGUED HOSPITALS. EXPERIENCED NURSES ARE SCARCE, AND NURSES WITH COMMUNITY HEALTH AND ACUTE-CARE EXPERIENCE -- NECESSARY TO CARE FOR TODAY'S MORE ACUTELY ILL HOME CARE PATIENT -- ARE EVEN MORE SCARCE.

THE OUTLOOK FOR COMMUNITY AND HOME HEALTH SERVICES IS NOT PROMISING. DURING PREVIOUS SHORTAGE YEARS, NURSES LEFT HOSPITAL EMPLOYMENT FOR POSITIONS IN COMMUNITY NURSING. THE LURE OF COMMUNITY AND HOME HEALTH POSITIONS WAS NOT SALARIES, AS WAGES WERE OFTEN LOWER IN COMMUNITY SETTINGS. INSTEAD, HOME CARE OFFERED REGULAR WORKING HOURS, NO SHIFT WORK, WEEKENDS OFF AND, MOST IMPORTANT, A SETTING THAT WAS MORE NURSING ORIENTED, GENERALLY DEVOID OF PHYSICIAN DOMINATION AND ONE THAT FOSTERED INDEPENDENT DECISION-MAKING, AUTONOMY AND GREATER PROFESSIONAL SATISFACTION.

CHANGES IN HOME CARE DELIVERY SYSTEM

TODAY, MANY OF THESE ATTRACTIONS ARE ABSENT FROM THE COMMUNITY SETTING. NURSES WORK EVENINGS, WEEKENDS, AND EVEN NIGHT SHIFTS. THE PATIENT ACUITY LEVEL HAS BECOME SO HEAVY THAT NURSES' FRUSTRATION LEVEL IS ON A PAR WITH THAT OF THEIR COLLEAGUES WHO WORK IN ACUTE CARE SETTINGS. PATIENTS WHO WERE ONCE THOUGHT TO BE TOTALLY UNMANAGEABLE AT HOME ARE NOW PART OF A NURSE'S USUAL CASE LOAD. THE AMOUNT OF PAPERWORK HAS ALSO DRAMATICALLY INCREASED. IN ORDER TO MANAGE THEIR CASE LOADS AND ESCALATING PAPERWORK, MANY NURSES LEAVE THE AGENCY EARLY IN THEIR SHIFT, VISIT THEIR PATIENTS AND TAKE THEIR PAPERWORK HOME TO COMPLETE. THIS CANNOT BE DELEGATED, GIVEN THE NATURE OF REQUESTS FOR HOME CARE INFORMATION, AND IT UNDULY CUTS INTO TIME APPROPRIATELY SPENT IN PATIENT CARE. OFTEN, FOLLOWING SUBMISSION OF EXCESSIVE PAPERWORK, NURSES BECOME EVEN MORE DISCOURAGED AS THE PATIENT CARE THEY PROVIDE IS FREQUENTLY AND ARBITRARILY DENIED FOR REIMBURSEMENT BY FISCAL INTERMEDIARIES WHO DO NOT RECOGNIZE THE VALUE OF THEIR PROFESSIONAL JUDGMENTS.

MANY HOME CARE AGENCIES HAVE GROWN FROM SMALL CONCERNS TO LARGE CORPORATES AND NURSES ARE MOVED FURTHER AWAY FROM DECISION-MAKING PROCESSES. IT APPEARS THAT THE PROBLEMS OF THE HOSPITAL INDUSTRY THAT DROVE NURSES AWAY ARE NOW PART OF HOME CARE. AND, HOME CARE SALARIES ARE OFTEN NOT COMPETITIVE WITH HOSPITAL SALARIES.

THE SHRINKING POOL OF BACCALAUREATE NURSE GRADUATES POSES REAL PROBLEMS FOR COMMUNITY-BASED AGENCIES. NURSES WITH BSN DEGREES FORM THE BULK OF COMMUNITY HEALTH STAFF BECAUSE THE BACCALAUREATE NURSING °PROGRAMS HAVE USUALLY PROVIDED THE EDUCATIONAL AND CLINICAL EXPERIENTIAL BASE FOR NURSING PRACTICE IN THE MORE INDEPENDENT COMMUNITY SETTING. THIS IS DIFFERENT FROM THE HOSPITAL SETTING AND REQUIRES AN UNDERSTANDING OF COMMUNITY SYSTEMS, PUBLIC HEALTH PRINCIPLES AND A FAIR AMOUNT OF INDEPENDENT NURSING JUDGMENTS. WITH THE ADVENT OF THE DRGS AND MORE HIGH-TECH SERVICES BEING PROVIDED IN THE HOME, AGENCIES HAVE TURNED INCREASINGLY TO NURSES WITH STRONG HOSPITAL EXPERIENCE. SINCE THESE NURSES OFTEN LACK COMMUNITY HEALTH EXPERIENCE, IT TAKES A LOT OF EDUCATION ON THE AGENCY'S PART TO ORIENT THEM AWAY FROM RELYING ON HOSPITALS AND PHYSICIANS FOR SOLUTIONS TO PROBLEMS THAT TRULY INVOLVE NURSING MANAGEMENT, CASE MANAGEMENT AND NURSING DECISION-MAKING IN THE HOME SETTING. CONVERSELY, SOME EXPERIENCED HOME CARE STAFF ARE OVERWHELMED BY THE ACUITY AND HIGH-TECH NEEDS OF PATIENTS DISCHARGED "QUICKER AND SICKER" FROM HOSPITALS SINCE THE ADVENT OF THE HOSPITAL DRG SYSTEM.

THE LICENSED PRACTICAL NURSE

LICENSED PRACTICAL OR VOCATIONAL NURSES FORM ONLY A SMALL PORTION OF HOME CARE PERSONNEL. GENERALLY HOME CARE AGENCIES CANNOT UTILIZE THE SKILLS OF THE LPN BECAUSE OF LICENSURE RESTRICTIONS AND EDUCATIONAL PREPARATION. WHEN THEY ARE EMPLOYED IN HOME CARE THEY ARE OFTEN UNDERUTILIZED AND FREQUENTLY PERFORM TASKS MORE APPROPRIATELY ASSIGNED TO THE HOMEMAKER-HOME HEALTH AIDE. THERE IS NO ROOM FOR ADVANCEMENT. THEIR ROLE AS TECHNICAL NURSES IS IN LIMBO, OWING TO THE CONTROVERSY OVER WHAT GROUP IN NURSING WILL INHERIT THE TECHNICAL ROLE. AS THEIR SCHOOLS ARE CLOSING, THEIR POTENTIAL FOR PLAYING A FUTURE ROLE IN HOME CARE WILL BE EXTREMELY LIMITED UNTIL THERE IS SOME RESOLUTION OF THE EDUCATIONAL REQUIREMENTS FOR LPNS.

THE HOMEMAKER-HOME HEALTH AIDE

THE ROLE OF THE HOMEMAKER-HOME HEALTH AIDE HAS BECOME INCREASINGLY IMPORTANT SINCE THE ADVENT OF MEDICARE AND MEDICAID. IN MANY WAYS, THE HOMEMAKER-HOME HEALTH AIDE IS THE BACKBONE OF HOME CARE. FOR THE PATIENT, IT IS THE HOMEMAKER-HOME HEALTH AIDE WHO SPELLS THE DIFFERENCE BETWEEN INSTITUTIONALIZATION AND DEPENDENCY, AND CARE AT HOME AND INDEPENDENCE. THESE WORKERS PERFORM A VARIETY OF TASKS IN THE HOME, FROM PERSONAL CARE TO MEAL PREPARATION AND LIGHT HOUSEKEEPING. IN SPITE OF THEIR VALUABLE SERVICES, HOMEMAKER-HOME HEALTH AIDES ARE AMONG THE LOWEST PAID HEALTH-CARE WORKERS, PLACING THEM AT OR BELOW THE POVERTY LEVEL. AS A RESULT, TURNOVER IS HIGH AMONG THESE EMPLOYEES. A WORKING PARENT DOES NOT MAKE ENOUGH TO PAY FOR CHILD-CARE. THEY HAVE TRANSPORTATION PROBLEMS, BECAUSE AN AUTOMOBILE IS ECONOMICALLY OUT OF THEIR REACH AND PUBLIC TRANSPORTATION IS NOT ALWAYS ACCESSIBLE TO MANY PATIENTS' HOMES. IN ADDITION TO LOW WAGES, HEALTH INSURANCE AND OTHER EMPLOYEE BENEFITS ARE NOT UNIVERSALLY AVAILABLE AND EMPLOYMENT IS OFTEN ON A PART-TIME BASIS. IT IS NO WONDER THAT MANY WORKERS LEAVE HOME CARE TO WORK IN THE GREENER PASTURES OF RETAIL SALES AND FAST-FOOD CHAINS.

IN A RECENT U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORT ON HOME HEALTH AIDE SERVICES FOR MEDICARE PATIENTS, INSPECTOR GENERAL KUSSEROW CONCLUDED: "RECRUITMENT, HIRING AND RETENTION OF HOME HEALTH AIDES ARE MAJOR PROBLEMS FOR MANY AGENCIES WHICH OFFER LOW PAY AND LIMITED BENEFITS. THESE AGENCIES DO NOT ATTRACT THE MOST RELIABLE EMPLOYEES AND EXPERIENCE A VERY HIGH TURNOVER RATE."

EVEN IN INSTANCES WHERE WAGES ARE ADEQUATE, THE HOMEMAKER-HOME HEALTH AIDE HAS FEW OPPORTUNITIES TO ATTAIN A MINIMAL DEGREE OF JOB SATISFACTION. THERE IS LITTLE OR NO ADVANCEMENT, THEY ARE ISOLATED FROM THEIR PEERS BECAUSE THEY WORK ALONE IN THE HOME AND, AS THE INSPECTOR GENERAL'S REPORT INDICATED, THE SUPERVISION AND SUPPORT THEY RECEIVE FROM PROFESSIONAL STAFF IS OFTEN INADEQUATE. PROFESSIONAL STAFF HAVE PROBLEMS KEEPING UP WITH HOMEMAKER-HOME HEALTH AIDES BECAUSE OF THE HIGH TURNOVER AND ABSENTEEISM.

SOLUTIONS - WAGES AND FINANCING

THE MOST OBVIOUS AND SHORT RANGE SOLUTION TO THE CURRENT SHORTAGE IS TO INCREASE SALARIES AND WAGES FOR HOME CARE NURSING PERSONNEL. IT IS WELL KNOWN THAT SALARIES FOR REGISTERED NURSES HAVE NOT KEPT PACE WITH EITHER THE COST OF LIVING OR THE SALARIES OF OTHER FEMALE-DOMINATED PROFESSIONS. MANY LABOR EXPERTS BELIEVE THAT THE CONTINUED LOW SALARIES FOR REGISTERED NURSES ARE THE KEY ELEMENT HOLDING DOWN SALARIES OF PARAPROFESSIONAL HEALTH CARE WORKERS. LOW SALARIES ARE TIED TO THE DEVALUING OF A SERVICE, WHICH IN TURN LEADS TO POOR IMAGE AND LOW JOB SATISFACTION.

RAISING SALARIES AND WAGES FOR HOME CARE NURSING PERSONNEL WILL BE DIFFICULT, IF NOT IMPOSSIBLE, WITHOUT CONCOMITTANT INCREASES IN MEDICARE AND MEDICAID RATES. ALTHOUGH HOME CARE IS NOT CURRENTLY UNDER THE PROSPECTIVE PAYMENT SYSTEM, HOME CARE COST LIMITS HAVE BEEN IN PLACE SINCE WELL BEFORE DRGS. THESE LIMITS HAVE TIGHTENED. THE MARKET BASKET WAGE AND LABOR INDEX USED FOR HOME CARE COST LIMITS IS COMPLETELY OUT OF TOUCH WITH THE COST OF LIVING AND PREVAILING COMMUNITY WAGES. RETROACTIVE DENIALS FOR SERVICE AND THE GRAMM-RUDMAN CUTS IN COST REIMBURSEMENT HAVE HAD A DEVASTATING EFFECT ON HOME CARE REVENUES. UNLIKE HOSPITALS, HOME CARE COSTS ARE PREDOMINANTLY SALARY COSTS. HOME CARE AGENCIES DO NOT HAVE THE OVERHEAD OR CAPITAL EQUIPMENT COSTS INCURRED BY INSTITUTIONS. THERE IS SIMPLY NO ROOM FOR INCREASING SALARIES.

WAGES AND BENEFITS MUST BE INCREASED FOR NURSING PARAPROFESSIONAL WORKERS. THIS MEANS THAT NOT ONLY MUST MEDICARE INCREASE COST LIMITS FOR HOME CARE BUT MEDICAID MUST DO SO AS WELL. AN INCREASE IN MEDICAID REIMBURSEMENT RATES IS ESSENTIAL TO ANY ADJUSTMENT IN WAGES FOR PARAPROFESSIONALS WHO SERVE A LARGE PROPORTION OF THE MEDICAID POPULATION. AT THE VERY LEAST, POTENTIAL WORKERS MUST BE ABLE TO CHOOSE WORK FOR WAGES AND BENEFITS THAT ARE BETTER THAN WELFARE.

LONG RANGE ECONOMIC SOLUTIONS MUST INCLUDE A RETHINKING OF WHERE WE AS A NATION SET OUR HEALTH CARE FINANCING PRIORITIES. THE EMPHASIS HAS BEEN ON ACUTE CARE, WITH A PITTANCE GOING TO PREVENTION AND LONG-TERM CARE. CHILDREN, THE POOR, THE DISABLED AND THE ELDERLY, OUR MOST VULNERABLE POPULATIONS, ARE ALSO THE MOST IN NEED OF PREVENTIVE AND LONG-TERM CARE SERVICES. IT IS NO COINCIDENCE THAT NURSING SERVICES ARE CLOSELY LINKED TO THESE GROUPS.

ROLE OF EDUCATION

INCREASING ACCESS TO EDUCATIONAL PROGRAMS FOR ALL LEVELS OF NURSING PERSONNEL IS ANOTHER SHORT RANGE SOLUTION. FEDERAL SUPPORT FOR PROFESSIONAL NURSING EDUCATION HAS DECLINED FROM AN ALL-TIME HIGH OF $160.6 MILLION IN 1973 TO $53.3 MILLION IN 1987. THERE IS NO QUESTION ABOUT THE EFFECTIVENESS OF THE NURSE TRAINING ACT IN STIMULATING UNDERGRADUATE NURSING ENROLLMENTS. THERE IS A CLEAR POSITIVE RELATIONSHIP BETWEEN THE NUMBER OF DOLLARS GOING TO BASIC NURSING EDUCATION FUNDS HAVE DROPPED FOR ALL PROGRAMS, FUNDING FOR UNDERGRADUATE STUDENTS HAS BEEN CUT THE MOST.

NURSES HAVE TRADITIONALLY COME FROM MIDDLE CLASS AND EMERGING MIDDLE CLASS FAMILIES. TODAY, FOR MANY OF THESE FAMILIES, COLLEGE IS OUT OF REACH. STUDENT LOANS ARE NOT READILY AVAILABLE AND THE LONG RANGE PAY-OFF IN TERMS OF EARNING POWER IS ABSENT FOR THE NURSE. IT IS EVEN MORE DIFFICULT FOR MINORITIES AND ECONOMICALLY DISADVANTAGED INDIVIDUALS TO ACHIEVE THE GOAL OF COLLEGE. SCHOLARSHIPS, TRAINEESHIPS, GRANTS AND LOANS MUST BE MADE AVAILABLE TO UNDERGRADUATE NURSING STUDENTS AND TO PARAPROFESSIONAL STUDENTS. IT IS ENCOURAGING TO SEE THE MANY STATE LEGISLATURES THAT CURRENTLY HAVE LEGISLATION PROPOSING SUCH PROGRAMS. AT THE FEDERAL LEVEL, CONGRESS WILL BE CONSIDERING THE REAUTHORIZATION OF THE PROFESSIONAL NURSE EDUCATION ACT. THERE IS SOME INDICATION THAT THERE WILL BE PROVISIONS THAT ADDRESS THESE ISSUES.

IT IS IMPORTANT THAT EDUCATIONAL FUNDING FOCUS ON A NURSING PARAPROFESSIONAL AS WELL AS REGISTERED NURSE PROGRAMS. ALTHOUGH MANY NURSE EDUCATORS BELIEVE THAT CAREER LADDERS ARE AN INAPPROPRIATE ROUTE FOR PROFESSIONAL EDUCATION, FOR MANY POTENTIAL NURSES, CAREER LADDERS ARE THE ONLY WAY THEY CAN ATTAIN THE ULTIMATE GOAL OF COLLEGE. CAREER LADDERS OFFER THE OPPORTUNITY FOR ADVANCEMENT AND CAN DO MUCH TO ENHANCE WHAT HAS BEEN PERCEIVED AS A DEAD-END JOB.

LONG RANGE SOLUTIONS IN EDUCATION SHOULD INCLUDE SOME RESOLUTION OF THE ROLE OF NURSING PERSONNEL AT VARIOUS LEVELS AND THE EDUCATIONAL PREPARATION, LICENSURE AND CERTIFICATION NECESSARY FOR EACH LEVEL.

THE SOLUTIONS FOR THE SHORTAGE, LIKE THE REASONS FOR THE SHORTAGE, ARE NOT NEW. INCREASED WAGES, FEDERAL AND STATE SUPPORT FOR NUSING EDUCATION AND NURSING SERVICES. TODAY'S NURSES AND NURSING PARAPROFESSIONALS WANT INCOME, RESPECT, AUTONOMY AND IMPROVED WORKING CONDITIONS. THE RESTRUCTURING OF THE ENTIRE HEALTH CARE DELIVERY SYSTEM, IN THE LONG RUN, WITH THE GREYING OF AMERICA AND THE IMPENDING CRISIS IN LONG-TERM CARE, MAY WELL BE THE ONLY ALTERNATIVE.